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Office of Administrative Law Judges
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Issue Date: 19 January 2006

CASE NO.: 2005-LHC-00081

OWCP NO.: 18-020714

In the Matter of:

BOB H. RAY,
Claimant,
v.

SEA-LAND SERVICES, INC./CSX LINES,
Employer,

CRAWFORD AND CO.,
Carrier.

Appearances:

Newton Brown, Esq.,
For the Claimant

Frank B. Hugg, Esq.,
For the Employer

BEFORE: GERALD M. ETCHINGHAM
Administrative Law Judge

DECISION AND ORDER DENYING CLAIMANT'S PETITION FOR MODIFICATION

This case arises under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901 *et seq.* (the "Act"). Claimant Bob Ray ("Claimant") filed a petition for modification pursuant to section 22 of the Act based on an alleged deterioration of his physical and economic conditions. A hearing was held on July 18, 2005 and July 21, 2005 in Long Beach, California. Claimant's Exhibits ("CX") 1-14 and Employer's Exhibits ("EX") 1-14 were admitted into evidence. All parties were represented by counsel, and at the close of the hearing the record was left open for the submission of post-trial briefs, which were filed both by Claimant and Employer and became part of the record on October 24, 2005 as ALJX 1 and ALJX 2, respectively.

STIPULATIONS

At the hearing, the parties stipulated to the Claimant's average weekly wage, which was found to be $587.62 by Judge Schneider in his 1988 decision. TR at 13. Because there is substantial evidence in the record to support this stipulation, I accept it. CX 4 at 4-5.

ISSUES FOR RESOLUTION

The unresolved issues in this matter are:

1. whether Claimant has experienced a change in his physical and/or economic condition entitling him to modification of the 1988 award; and
2. what, if any, further medical treatment Claimant should receive.

TR at 13.

FINDINGS OF FACT

Claimant, Bob Ray, who was born on May 28, 1942, worked as a driver for Sea-Land Services in Long Beach, California.

Prior Injuries

While working for Sea-Land, Claimant was injured on May 21, 1973. EX 2 at 39.4; EX 2 at 89, 94; EX 2 at 176; EX 10 at 2. He was referred to a "company doctor" who treated him with medications and heat, but his symptoms continued. EX 2 at 176. He then saw a chiropractor, H. Gartley, who took x-rays and treated him with spinal manipulation treatments in May and June 1973. EX 2 at 161, 176. Claimant's condition improved and he was off work less than a week, but he has had occasional ongoing symptoms. EX 2 at 159, 176.

Again, in or around 1976, Claimant injured his neck and spine while working. EX 2 at 89; CX 10 at 2. He received treatment at Pacific Hospital, from the "company doctor," and then was referred to a chiropractor for some spinal manipulations. EX 2 at 89, 176. He was off work for approximately a week. EX 2 at 159; CX 10 at 3. Claimant experienced marked improvement upon treatment but has had increased residual low back and right lower extremity pain after this incident. EX 2 at 89

1983 Injury

Claimant was injured on October 3, 1983 while working as a driver and freight hauler for Sea-Land Services. TR at 24-25; TR at 46; EX 2 at 216-17. Claimant was shuttling a rig in a staging area of Long Beach harbor. He was backing his rig under a container to connect it. The container was fully loaded and heavy, and Claimant was having problems hooking it up. EX 2 at 68, 87. As Claimant was twisting around to look behind him while backing up, the rig hit the container hard and Claimant was thrown around inside the truck. EX 2 at 39.1, 87. He felt immediate low back pain, with radiating pain to the right lower extremity. EX 2 at 87.

Claimant reported the injury to the company dispatcher and was sent for medical

attention. EX 2 at 87. Claimant reported to the emergency room at Pacific Hospital, where he was given x-rays and was prescribed medications and physical therapy. CX 3 at 1; EX 2 at 88.

Treatment and Evaluations 1983-1988

Claimant was seen by Dr. Prichard on October 13, 1983 and diagnosed as having a low back strain. EX 1 at 3. Claimant was discharged to work, but never returned to work at Sea-Land. EX 2 at 39.1, 176.

On October 26, 1983, Dr. Roger Thill found that Claimant had suffered severe strain and sprain of the musculoligamentous skeletal system of the cervical and lumbar spine. CX 2; EX 1 at 3; EX 2 at 215. Dr. Thill directed that Claimant should be off work for home rest and receive physiotherapy. EX 2 at 39.1; EX 2 at 215. Claimant was again seen by Dr. Thill on November 15, 1983, and was noted to be improving but remained temporarily totally disabled. EX 2 at 95.

On December 2, 1983, Dr. Larry P. Bilodeau, M.D. performed a CT scan of Claimant's lumbar spine, which showed no evidence of disc herniation. EX 1 at 3; EX 2 at 212; EX 16. The impression was disc material posterior and posterior/lateral on both right and left sides at L4 and L5-S1 levels. EX 2 at 95; EX 2 at 212; EX 16.

Claimant was admitted to Pacific Hospital on December 8, 1983. EX 2 at 207. Claimant was seen by Dr. Jay Scarborough, M.D., for a neurological consultation on December 9, 1983. EX 2 at 95; EX 2 at 206. At that time, Claimant was in bed, in traction. EX 2 at 95. Dr. Scarborough's impression was chronic lumbosacral and sacroiliac sprains. EX 2 at 95; EX 2 at 206. Dr. Scarborough opined that a myelogram was not needed at that time, but might be necessary if Claimant's symptoms did not improve over the next 10 days. EX 2 at 206.

Around December 9, 1983, Claimant came under the care of Dr. Josef Strazynski, D.O., a family practitioner/osteopathic physician, who diagnosed lumbosacral pain, without disc herniation. EX 1 at 4.

Dr. Strazynski was Claimant's treating physician from this time until the mid-1990s when he moved from the country and transferred Claimant's care to Dr. Ali Haddadzadeh. During the time he was under Dr. Strazynski's care, Claimant was treated for low back pain that radiated into the lower extremities, as well as a pelvic shift that resulted in a functionally shorter left leg and a significant limp. EX 2 at 39.6. Dr. Strazynski's office treated Claimant frequently (three to four times per week) with "vigorous physical therapy treatment with utilization of hydroculators, ultrasound, and transcutaneous electrical neuro-stimulation" as well as osteopathic manipulations. EX 2 at 119. Over various visits and reports, Dr. Strazynski stated that Claimant's disability makes it impossible for him to work. EX 1 at 4; EX 2 at 39.1.

Claimant was seen and treated by Dr. Strazynski on numerous occasions, including March 6, 1984; June 8, 1984; June 14, 1984; July 24,1984; August 3, 1984; November 28, 1984; January 23, 1985; February 13, 1985; June 4, 1985; June 21, 1985; September 3, 1985; October 25, 1985; January 15, 1986; March 19, 1986; May 5, 1986; August 28, 1986; August 8, 1987; September 11, 1987; and October 5, 1987. EX 2 at 39.2-39.3; EX 2 at 95-97; EX 2 at 199.

On February 6, 1984, Dr. James Roe, Orthopaedic Surgeon, did an orthopaedic consultation and diagnosed a musculoligamentous tendinous strain to the lumbosacral spine. EX 1 at 4; EX 2 at 39.1; EX 2 at 201. Dr. Roe noted complaints of burning or stabbing pain in the low back with a pins-and-needles sensation in the left leg. EX 2 at 39.6; EX 2 at 201. Dr. Roe recommended at a myelogram, CT scan, lab studies, and a psychometric evaluation. EX 2 at 39.1, 39.6; EX 2 at 95; EX 2 at 204. He also prescribed medication and stated that Claimant was unable to return to work. EX 2 at 39.1; EX 2 at 95; EX 2 at 204. Dr. Roe issued a report on February 17, 1984, reiterating his opinion that more tests were needed to rule out a herniated nucleus pulposus. EX 2 at 200.

A myelogram was conducted on April 24, 1984 and interpreted by Dr. Bilodeau. EX 2 at 96. The impressions were persistent anterior defect at L4-L5 level, but otherwise unremarkable. EX 2 at 96. However, Claimant had negative reactions to the procedure and had to be admitted to the hospital with severe cephalgia on May 1, 1984. EX 2 at 161. This experience led to Claimant's reluctance to have further myelograms or any other back or neck surgery.

Dr. Scarborough reviewed the myelogram on May 8, 1984, and found that it showed minor problems with the lumbar spine, and Claimant was found not to be a candidate for back surgery. EX 1 at 11; EX 2 at 96, 195; EX 16.

On August 6, 1984, Bridget Price, a rehabilitation nurse, issued a report in which she noted Dr. Strazynski's opinions that Claimant was not able to participate in any vocational rehabilitation since he was not permanent and stationary and was limited in his activities. EX 2 at 188. She recommended monthly visits with Claimant "to assess his progress, and increase if any in stamina" and continued contact with Dr. Strazynski regarding Claimant's "ability to participate in vocational rehabilitation in the future." EX 2 at 188.

Nurse Price issued reports on April 24, 1984 (EX 2 at 197); May 14, 1984 (Ex 2 at 193); July 2, 1984 (Ex 2 at 191-92); July 25, 1984 (Ex 2 at 190); August 25, 1984 (EX 8 at 448); October 6, 1984 (EX 8 at 448), October 19, 1984 (EX 5 at 297-303), October 29, 1985 (EX 2 at 100); January 7, 1986 (EX 2 at 100), in which she provided updates on his treatments, disability, activities, and vocational rehabilitation options.

On September 12, 1984, Joseph Hughes, D.P.M. conducted a podiatric consultation. EX 2 at 187. He evaluated Claimant's complaint of having one leg longer than the other. He concluded that Claimant had a functional limb length discrepancy, which could be corrected by orthotics. EX 2 at 39.3. Claimant was given an orthotic for his right shoe. EX 2 at 161.

On October 25, 1984, Claimant was evaluated by Patrick Hartley, a vocational consultant. EX 2 at 97. Claimant also met with Mr. Hartley and Mr. Philip Lewis, another vocational consultant, on other dates, including December 19, 1984; February 11, 1985; March 4, 1985; April 2, 1985; April 29, 1985; and June 1, 1985. EX 2 at 97-99.

In or around 1985, Claimant and his wife divorced. CX 10 at 4. Claimant raised their two children, who were about four and six at that time, and even home-schooled them for a few years in high school. CX 10 at 4, 8, 15.

On January 1, 1985, Dr. Stanley Robboy, M.D. an orthopedic surgeon, evaluated Claimant, diagnosed a lumbosacral strain, and found him to be permanent and stationary. EX 1 at 4. On January 30, 1985, Dr. Robboy issued a report. EX 2 at 175. He viewed X-rays of the lumbosacral spine that showed minimal left lumbar scoliosis, moderate decrease in the L5-S1 disc space, minimal anterior hypertrophic spurring at the superior margin of L5. EX 2 at 39.3-39.4. Dr. Robboy noted, "Although his CAT scan was reported to reveal herniation of disc material at the L4-5 and L5-S1 levels, a subsequent myelogram apparently did not reveal significant lesions at these levels." EX 2 at 183. He diagnosed chronic lumbosacral myofascial strain but ruled out any radiculopathy, sciatic irritability, or disc lesion. EX 2 at 39.4, 171, 183. Dr. Robboy noted that Claimant had had only "partial transient relief with treatment." EX 1 at 39.4; EX 2 at 175, 182. Dr. Robboy recommended home exercise, anti-inflammatory medications, and weight loss. EX 2 at 39.6.

Claimant was found to be permanent and stationary as of January 30, 1985. CX 4 at 3; EX 2 at 128; EX 8 at 439.

In March 1985, Dr. Strazynski issued a report summarizing the treatments, tests, and progress since March 6, 1984. EX 2 at 173. In particular, he noted that Claimant had been receiving physical therapy two to three times per week and had required some additional medications, and that Claimant continued to be reluctant to undergo another myelogram. EX 2 at 173-74. Dr. Strazynski stated that surgery may be necessary, in light of Claimant's "very slow and relatively minimal progress." EX 2 at 174.

On May 7, 1985, Dr. Robboy evaluated Claimant's ability to work with special attention to the amount of lifting, bending, pushing, stooping, squatting and carrying required. EX 2 at 39.4, 171. Dr. Robboy concluded that Claimant could return to his regular work and no occupational rehabilitation was required. EX 2 at 171.

On June 4, 1985, Dr. Strazynski issued a report requesting another myelogram "to reevaluate [the] condition of patient's inter-vertebral disc and possibly opt for surgical intervention." EX 2 at 170.

On June 21, 1985, Dr. Strazynski issued a report in which he responded to Dr. Robboy's report. EX 2 at 168. Dr. Strazynski noted differences in their findings regarding Claimant's pelvic rotation and his paraspinal spasms. EX 2 at 168. Dr. Strazynski also emphasized that "the range of motion of the spinal axis as well as of the lower extremities varies from day to day depending on patient's activities and amount of paraspinal spasms," which in turn cause "significant intermittent changes in his gait, posture and amount of pain." Ex 2 at 168. Dr.

Strazynski also contested Dr. Robboy's opinion that Claimant could increase his activity level and return to work through use of "time limited therapy" on the grounds that such therapy had been unsuccessful. EX 2 at 169l.

On August 1, 1985, Claimant was seen by Dr. Charles Booth, M.D., an orthopaedic surgeon, who was utilized as an Agreed Medical Examiner. EX 2 at 39.4, 39.6; EX 2 at 158. Dr. Booth reviewed x-rays of the lumbosacral spine and found that there appeared to be spina bifida occulta of the first sacral segment, slight lateral curvature of the spine, and tendency toward some anterior and posterior osteophytes especially at the L4-5 level. EX 2 at 39.4, 163. The lateral view x-ray of the cervical spine showed that the disc spaces and vertebral bodies were "well preserved." EX 2 at 164. He diagnosed recurrent sprains to the lumbosacral spine and probable lower lumbar disc protrusion. EX 1 at 4; EX 2 at 39.4, 164.

Dr. Booth recommended a CT scan, which was conducted on September 3, 1985 by Dr. Stephen Rothman. EX 2 at 152, 165. Dr. Rothman found some degeneration of L5-S1 disc space without disc herniation and slight narrowing of left neural foramen. CX 8 at 23; EX 1 at 4, 11; EX 16. Dr. Booth also reviewed this scan in a supplemental report dated September 13, 1985 and found right and left facet hypertrophy of a mild to moderate degree at L5-S1 and mild to moderate left neural foraminal stenosis. EX 2 at 39.4; EX 2 at 152. He believed Claimant was not a candidate for surgery, but that he "may have an occasional exacerbation requiring a visit to an orthopedist for a short course of physical therapy and/or medication." EX 2 at 39.6l, 153.

Dr. Strazynski issued a report on September 3, 1985, noting no significant change in Claimant's condition except for gradual increase in the myositis of the lumbosacral area and increase in muscular spasms, due to Claimant's physical activity and inability to afford all of his therapy sessions. EX 2 at 155. He also requested a Transcutaneous Electrical Neural Stimulation (TENS) unit for Claimant, which had been helpful. EX 2 at 155-56.

On October 25, 1985, Dr. Strazynski issued a full report. EX 2 at 146. He noted that Claimant's "present condition is improved by approximately 30% from the time of his initial evaluation" following the 1983 injury. EX 2 at 147. Dr. Strazynski opined that Claimant was permanently totally disabled "based on the fact that during the course of treatment from October 1983 till present patient was unable to progress in his therapy to his pre-injury health status." EX 2 at 148. Dr. Strazynski opined that although Claimant could not return to his previous work, he "could be trained in a position not requiring more than moderate physical effort." EX 2 at 149.

Dr. Strazynski issued reports/billings to Crawford and Company on December 18, 1985 (EX 2 at 145); January 15, 1986 (EX 2 at 143); March 19, 1986 (EX 2 at 142); May 6, 1986 (EX 2 at 141); July 17, 1986 (EX 2 at 140); August 11, 1986 (EX 2 at 139); August 28, 1986 (EX 2 at 138); September 23, 1986 (EX 2 at 136); June 30, 1987; August 8, 1987; October 5, 1987; October 20, 1987 (EX 5 at 285-87).

An MRI conducted by Dr. Bilodeau on August 30, 1986 showed evidence of disc desiccation at L4-5 and L5-S1 with central bulging posteriorly at these interspaces, and obliteration of lateral recess on left side at L4-5 by disc material, with moderate stenosis of right and left intervertebral foramina at this disc space. CX 8 at 23; EX 2 at 39.1, 54, 137. On

September 23, 1986, Dr. Strazynski issued a report stating that this MRI had confirmed herniation of the spinal disks. EX 2 at 136.

Beginning in September 1986, Claimant received vocational counseling and assistance from Vocational Exploration Services through the OWCP. EX 5 at 274, 281, 295. Vocational tests were administered on September 17, 1986. EX 5 at 282-84. A labor market survey of credit and collections positions was prepared on October 27, 1986. EX 5 at 275-279.

On October 7, 1986, Dr. Strazynski completed a work restriction evaluation. EX 5 at 289. Claimant's work restrictions included no lifting, bending, squatting, climbing, or twisting, and only intermittent sitting, walking, kneeling, or standing for one to two hours per day. EX 5 at 289. Dr. Strazynski opined that Claimant could not work full time and should not operate a motor vehicle. EX 5 at 289. He noted he was "unsure at present" whether Claimant was at maximum medical improvement. EX 5 at 289.

On October 30, 1986, a vocational rehabilitation plan and award was approved by the OWCP. EX 5 at 271. Under the plan, Claimant was to receive training at Carter Business Schools to be a credit clerk or collections clerk. EX 5 at 271. The training proceeded reasonably well through November 1986. EX 5 at 273.

On June 30, 1987, Dr. Strazynski requested a psychological consultation, as Claimant was suffering from "severe depression due to what he conceives failure as a father, husband and provider for his family" in addition to his physical conditions. EX 2 at 133.

On August 8, 1987, Dr. Strazynski wrote a letter to Claimant's attorney, Mr. Baker, memorializing a telephone conversation on August 3, 1987. EX 2 at 131. Dr. Strazynski stated that Claimant was "suffering from a severe case of neuritis, neuralgia and myositis" as well as "bulging of lumbar vertebrae, and tortion type malrotation of his pelvic girdle resulting in functionally shorter right lower extremity." EX 2 at 131. Dr. Strazynski noted that despite many attempts, Claimant was unable to work "due to the fact that he is unable to sustain one type of posture (i.e. sitting, standing, bending, etc) for a period of longer than fifteen to thirty minutes." EX 2 at 131. Therefore, Dr. Strazynski opined that Claimant was totally disabled and "should receive all benefits due him." EX 2 at 131.

Claimant was also evaluated by Dr. James Murphy on October 4, 1987. EX 1 at 4. Dr. Murphy's impression was status post lumbosacral strain superimposed upon degenerative disc disease. EX 1 at 4, EX 2 at 39.6. He apportioned Claimant's disability as 25% to the injury on October 3, 1983, 25% to the injury in 1977, and 50% to the injury in 1973. EX 2 at 129. Dr. Murphy stated that "[t]here has certainly been no indication for all of the continued physical therapy that the patient has received" and "[t]he MRI from Pacific Hospital dated 8/30/86 appears to have been markedly over-read." EX 2 at 129. Dr. Murphy disagreed with Dr. Booth's conclusions that Claimant could not return to his prior work. EX 2 at 130.

On September 8, 1988, Dr. Strazynski issued a report explaining the physical therapy treatments Claimant had been receiving and that these provided Claimant with relief of his symptoms for 12-72 hours. EX 2 at 119-120. Dr. Strazynski explained that Claimant had also

had limited relief from treatments, including hospitalization, immobilization, and direct injections to the spinal cord. EX 2 at 120. He also stated that two neurosurgeons, Dr. Scarborough and Dr. Kim, "recommended that surgery not be attempted due to the risk factors far out weighing possible benefits of such a procedure." EX 2 at 120. Finally, he emphasized Claimant's desire and attempts to return to work. EX 2 at 120.

At some points between the 1983 injury and the 1988 decision, Claimant worked temporarily as a welder's assistant and for a general contractor.

1988 Decision

A hearing was held on September 13, 1988 before Administrative Law Judge Schneider, and a decision was issued on December 28, 1988. CX 4 at 1. In that decision, Judge Schneider found that Claimant had sustained injuries to his back and psyche, and had reached the point of maximum medical improvement on January 30, 1985. CX 4 at 3. Judge Schneider found that Claimant's average weekly wage ("AWW") was $587.62 and his retained earning capacity was $350.00, making him entitled to $158.41 in permanent partial disability compensation. CX 4 at 5. Judge Schneider also awarded Special Fund relief under section 8(f). EX 4 at 6.

Treatment and Evaluations 1988-2001

Dr. Strazynski issued reports on February 3, 1989; April 20, 1990; and September 25, 1990, stating that Claimant continued to receive physical therapy two to three times per week, osteopathic manipulations, and medications. He experienced brief improvement following physical therapy but his condition was essentially unchanged. Dr. Strazynski also stated that Claimant remained totally disabled, because his chronic pain prevents him from working. EX 2 at 102, 113-115.

On October 1, 1990, Dr. Strazynski issued a report explaining that Claimant's "present condition is characterized by significant pelvic tilt with resulting myositis and neuritis involving the lower segments of his spinal cord. Several options of treatments have been discussed in the past with the patient, and many of them have been tried in the past (with the exception of a surgical approach)." EX 2 at 112.

On October 12, 1990, attorney Mr. Baker wrote to Dr. Strazynski, "It is my impression as confirmed by your patient that his condition has deteriorated since the Administrative Law Judge's decision in 1988. If this is in fact the case, I would be entitled to bring a motion for modification seeking additional compensation for Bobby's increased disability. I will however need a report from you stating that Mr. Ray's condition has deteriorated and how." EX 2 at 111.

On October 26, 1990, attorney Mr. Baker wrote Claimant and forwarded Dr. Strazynski's October 1, 1990 report. Mr. Baker stated, "The bottom line is Dr. Strazynski does not say you're worse. I, therefore, have no basis to move for modification of your award." EX 2 at 110.

On March 8, 1991, Dr. Strazynski wrote in a letter, "From the time of his first treatment, which continues until this time, the patient's condition remains stationary, and despite the

frequency of treatments rendered, as well as the strength of medications utilized, his condition is characterized by progressive deterioration and severe exacerbation of the pains related to his above mentioned injuries." EX 2 at 108. He emphasized that Claimant "is unable to undertake any employment secondary to the severity of his symptomatology which is characterized by severe pain secondary to significant pelvic tilt with resulting myositis and neuritis involving the lower segments of the spinal cord and lower extremities." EX 2 at 108. Dr. Strazynski also noted that Claimant's visits for physical therapy treatments had increased to three to four times per week due to the increased intensity of his symptoms. EX 2 at 109.

On May 19, 1992, attorney Mr. Baker wrote a letter responding to Dr. Strazynski's request to re-open Claimant's case on the grounds that he is totally disabled. EX 2 at 107.

Claimant was seen by Craig Morris, DC on June 3, 1993 for the purposes of a report to Crawford and Company, which was issued on July 12, 1993. EX 2 at 87. Claimant complained of low back pain, which was present 90% of the time. EX 2 at 88, 103. He also complained of radiating pain and numbness into his lower extremities, which was much stronger on the right. EX 2 at 89. He denied any pain in the cervical or thoracic spine and any pain or radicular symptoms in the upper extremities. EX 2 at 89. Chiropractor Morris' impression from the radiographic tests was left lateral inclination and mid to moderate degenerative changes. EX 2 at 94. He diagnosed a chronic recurrent lumbosacral strain with disc protrusions, a disc protrusion at L5-S1, and radiculopathy to the right lower extremity. EX 1 at 4; EX2 at 103. Chiropractor Morris noted that although Claimant had been found to be permanent and stationary, he "remains quite symptomatic, requiring continued consistent conservative care for symptomatic relief." EX 2 at 104. Chiropractor Morris recommended continued spinal manipulation and physical therapy (but less often), continued home care and exercises, and manipulation under anesthesia to remove scar tissue. EX 2 at 104.

Claimant's last physical therapy session with Dr. Strazynski's office was in May 1994. EX 8 at 442. Claimant has little documentation of medical care between May 1994 and July 2001, when he began treatment with Dr. Capen. TR at 76, 83. During this period, Dr. Strazynski had moved out of the country and Claimant's care had been transferred to Dr. Ali Haddadzadeh (sometimes referred to by others as "Dr. Haddad"). EX 2 at 39.7, EX 2 at 69. Claimant was seen by Dr. Haddadzadeh on November 3, 1997. EX 2 at 80. Claimant asserts that he did not receive much medical care over this period due to problems with receiving reimbursement for his medical bills and payments for treatments. TR at 75-83, 110-14.

On June 30, 2000, Dr. Pagiel Shechter examined Claimant and diagnosed cervical and lumbar radiculopathy and recommended an MRI. EX 8 at 445. This was the first record of Claimant complaining of numbness and weakness in his left leg and left arm/hand. EX 8 at 442.

MRIs of the cervical spine and lumbar spine were conducted on July 6, 2000. EX 2 at 76; CX 6 at 1-4. The impressions from the cervical spine MRI included moderate spondylosis, disk space narrowing at C4-5 and C6-7, mild to moderate facet arthrosis, neuroforaminal canal stenosis, and multiple disc/osteophytes at C3-4 and C5-6. EX 2 at 76; CX 6 at 3-4. The impressions from the lumbar spine MRI included moderate spondylosis, disc dessication and disc space narrowing at L4-5 and L5-S1, moderate to severe facet arthrosis, and neural foraminal

canal stenosis, small disc herniation at L4-5 and L5-S1. EX 8 at 455, EX 2 at 78; CX 6 at 1-2.

Treatment and Evaluations 2001-present

On June 26, 2001, attorney Mr. Baker notified Crawford and Company that Claimant elects to be treated by Dr. Daniel Capen, M.D. EX 3 at 218. Claimant designated Dr. Capen as his treating physician on July 17, 2001. EX 2 at 45. Dr. Capen's office submitted claims to Crawford and Company for all visits. EX 4 at 240-248.

Claimant initially visited Dr. Capen on July 17, 2001. CX 8 at 1; EX 2 at 68, 219. During that visit, Claimant complained of aching, stabbing pain in his low back; numbness and tingling in his left foot; numbness and tingling in his left hand and fingers; weakness in the lumbar region; and pain that is aggravated by bending, twisting, turning, or prolonged sitting, standing, or walking activities. EX 2 at 70. Claimant's pain drawing from July 17, 2001 indicates aching and stabbing pain in the low back and complaints with regard to the left hand and left foot. EX 3 at 220. Radiographs showed mild left-sided discogenic scoliosis with narrowing of the disc spaces at L3-4, L4-5, and L5-S1, with foraminal narrowing. CX 8 at 4; EX 2 at 71. Because these x-rays showed narrowing of the nerve canal and Claimant was having numbness and tingling in his upper and lower extremities, Dr. Capen ordered further tests to determine whether there was nerve compression. TR at 197-98. Dr. Capen also found asymmetry in the measurement of Claimant's calves, which he believed could be an indication of lumbar nerve compression and reason to do further testing. TR at 238-244. Dr. Capen diagnosed cervical discopathy, lumbar discopathy, and chronic mechanical spine pain. CX 8 at 5; EX 2 at 72. Dr. Capen referred Claimant for chiropractic care, lumbar epidural blocks and facet blocks for pain control, and an interferential unit. EX 2 at 72. He also prescribed physical therapy three times a week. EX 2 at 221.

Dr. Mette Hansen at Dr. Capen's office examined Claimant again on August 8, 2001 and August 16, 2001. CX 8 at 8; EX 2 at 60. At this time, Dr. Henry of Dr. Capen's office also conducted EMG/NCS tests. CX 8 at 8-12; EX 2 at 65-67. Dr. Hansen's impressions regarding the upper extremities were "severe focal left median neuropathy at the wrist with sensory axon loss in the third digital branch, demyelination of the forearm and prior versus chronic denervation changes in the left APB muscle; moderate focal right median neuropathy at the wrist with sensory axon loss and approximately 20 percent motor conduction block and demyelination in the forearm; prior versus chronic left C7 radiculopathy without active denervation at this time." CX 8 at 10-11; Ex 2 at 62-63. Dr. Hansen's impressions regarding the lower extremities were chronic right L4 and L5 radiculopathies with active denervation in the right L5 myotome and paraspinal muscles; chronic left L4 and L5 radiculopathies with evidence of chronic ongoing active denervation throughout the lumbar paraspinal muscles and evidence of axon loss in the left tibial motor distribution. CX 8 at 11; EX 2 at 63.

Dr. Capen concluded that these EMG tests were positive for L5 radiculopathy and "left sided cervical radiculopathy, moderate to severe carpal tunnel syndrome or nerve compression in the forearm and wrist," which was severe on the left and moderate on the right. TR at 198-99. He also concluded that Claimant suffered from nerve compression in the lumbar spine, cervical spine, and the wrists and hands. TR at 198-99. This was the first diagnosis of nerve root

compression. TR at 245-47.

On August 17, 2001, Dr. Herring in Dr. Capen's office evaluated Claimant. CX 8 at 15; EX 2 at 56. Claimant's pain drawing from August 17, 2001 showing numbness in the left hand and burning and aching in the low back. EX 3 at 222. Dr. Herring also reviewed the EMG results and diagnosed Claimant with cervical radiculopathy with nerve root impingement and lumbar radiculopathy with nerve root impingement. CX 8 at 16; EX 2 at 57. Dr. Capen, through Premier Physical Therapy, prescribed that Claimant should receive physical therapy three times a week. EX 2 at 58, 223; CX 8 at 17. Claimant was found to be temporarily totally disabled. CX 8 at 17; EX 2 at 58. Dr. Capen's office continued to find Claimant to be temporarily totally disabled through every subsequent visit. *See, e.g.*, CX 8 at 23, 27, 31, 64, 82.

Claimant initially received physical therapy on July 25, 2001, at which time his complaints were regarding constant low back pain and left hand pain, cramping, and numbness. EX 4at 258. The goals for physical therapy were to increase Claimant's range of motion and decrease his pain and muscle tightness. EX 4at 259. He continued to receive physical therapy up to three to four times per week, including on July 26, 2001 (EX 4 at 249); August 3, 2001 (EX 4at 250); October 31, 2001 (EX 4 at 251, 260-61); November 5, 7, 9, 12, 21, 26, 28, 30 2001 (EX 4 at 252-54); November 14, 2001 (EX 4 at 264); December 3, 2001 (EX 4 at 265); December 20, 2001 (EX 4 at 266); January 25, 2002 (EX 4 at 256, 267); February 1,7,15,21 (EX 4 at 257; February 21, 2002 (EX 4 at 268); February 28, 2002 (EX 4 at 269).

On October 1, 2001, Dr. Capen examined Claimant. CX 8 at 22; EX 2 at 52. Claimant's pain drawing indicates aching and stabbing pain in the low back and numbness in the left hand and left foot. EX 3 at 224. Diagnosis remained the same. Dr. Capen noted that due to fear, Claimant had not received any epidural injections, which he had recommended in August 2001. CX 8 at 21; EX 2 at 52. At that time, Dr. Capen requested that Claimant be provided a gym and pool membership for one year, and he prescribed acupuncture, physical therapy, and chiropractic treatment three times a week to help treat cervical and lumbar radiculopathy with nerve root impingement. EX 3 at 225-27; CX 9 at 19-20; EX 2 at 53-54. Although Dr. Capen's office continued to seek authorization, the request for a gym membership was never authorized. CX 8 at 34; EX 2 at 42; EX 3 at 229, 235; TR at 39.

On November 15, 2001, Dr. Capen examined Claimant for a progress report. CX 8 at 25; EX 2 at 49. Claimant's pain drawing indicates aching and stabbing pain in the low back and numbness in the left hand and left foot. EX 3 at 228. Claimant was found to have experienced some improvement from physical therapy and was to continue three times a week. EX 3 at 230; CX 8 at 24; EX 2 at 50. Diagnosis remained the same. Dr. Capen found that Claimant should be made eligible for vocational rehabilitation and retraining. CX 8 at 25; EX 2 at 51.

On January 16, 2002, Dr. Edward Mittleman of Dr. Capen's office evaluated Claimant. CX 8 at 29; EX 2 at 46. Claimant complained of an increase in the intensity of his pain and aching symptoms in his back and right leg, especially upon activity. EX 3 at 231; CX 8 at 30; EX 2 at 47. Claimant's pain drawing indicates aching and stabbing pain in the low back, aching in the right leg, and numbness in the left hand and left foot. EX 3 at 232. Diagnosis remained the same. Claimant was given an injection of dexamethasone, Depo Medrol and Marcaine. CX

8 at 30; EX 2 at 47. His physical therapy was reduced to once per week, but he was to continue home strengthening exercises. EX 3 at 233; CX 8 at 30; EX 2 at 47.

On February 22, 2002, Claimant was evaluated by Dr. Capen. CX 8 at 32; EX 2 at 40. Claimant's pain drawing indicates stabbing pain in the low back, aching in the right leg, and numbness in the left hand and left foot. EX 3 at 234. Dr. Capen diagnosed chronic right and left L4 and L5 radiculopathy, cervical discopathy, lumbar discopathy, and chronic mechanical spine pain. CX 8 at 33; EX 2 at 41. Dr. Capen released Claimant because "[h]e is totally not interested in any surgery at this time [,]" and "[s]urgery is the only treatment that is going to have a reasonable likelihood of helping him. There is nothing else that can be done other than surgery." CX 8 at 33-34; EX 2 at 41-42. Dr. Capen also stated, "The patient is 100% disabled and not able to compete in the open labor market. His disorder is totally and solely a work-related disorder." CX 8 at 34; EX 2 at 42.

On March 8, 2002, attorney Mr. Baker wrote to Dr. Capen asking him to opine specifically on whether Claimant was totally disabled at the time of his first visit on July 17, 2001 and whether Claimant's disability had increased since the 1988 award, including discussion of any "differences in terms of subjective and objective factors of disability and work restrictions." EX 3 at 236. On September 24, 2002, attorney Mr. Baker reiterated this request in light of an upcoming trial date. EX 3 at 237. On October 11, 2002, attorney Mr. Baker reiterated his request, specifically requesting that Dr. Capen investigate Claimant's current complaints and determine whether he is worse than at the time of the 1988 award. EX 3 at 238. This request was made in light of questions during Claimant's deposition on October 8, 2002 comparing Claimant's subjective complaints from 1985 to his present complaints. EX 3 at 238. Mr. Baker also requested that Dr. Capen comment on Claimant's ability to perform jobs included in certain vocational reports and labor market surveys. EX 2 at 238.

On October 9, 2002, Dr. Capen issued an "Orthopedic Supplemental Report," in which he reviewed Claimant's medical history, physicians' reports, and tests dating back to 1983. CX 8 at 36-41; EX 2 at 39.1-39.6. Dr. Capen acknowledged that he had not examined Claimant since February 22, 2002, but that it was his "opinion that [Claimant's] low back condition has deteriorated to the point that he is now 100 percent disabled." CX 8 at 43; EX 2 at 39.7. Dr. Capen opined, "This is all due to the natural progression of his October 13, 1983 injury." CX 8 at 43; EX 2 at 39.7. Dr. Capen noted that he had suggested surgery, but that Claimant "is fearful and chooses to live with the pain." CX 8 at 43. Thus, Dr. Capen expressed that unless and until Claimant is willing to consider surgery, he would remain permanently totally disabled because he was not responding to conservative treatments. CX 8 at 43; EX 2 at 39.7.

On March 14, 16, and 20, 2003, Claimant underwent surveillance. EX 13. Claimant was observed walking in and out of his house, drying off his car, driving a car, eating at a restaurant, using a dolly to move trash cans to the curb, bending, stooping, and kneeling. CX 8 at 50. On one of the days, he was observed walking with a limp. CX 8 at 50. Claimant was observed being active for four hours one day and five hours another day. TR at 230-31.

On March 20, 2003, Dr. Lorman completed a complex qualified medical evaluation for thoracic and lumbar spinal pain. EX 1. Dr. Lorman noted, "the patient proves to be a poor

historian as to time, person and place." EX 1 at 1. Dr. Lorman noted complaints of pain in the midthoracic spine radiating to the left upper extremity and pain in the lower lumbar spine radiating into the lower extremities with numbness in the left foot. EX 1 at 2. At the hearing, Dr. Lorman emphasized that Claimant did not complain of any neck or cervical spine pain during this visit. TR at 139-40. He found no evidence of herniated/ruptured lumbar disc or nerve compression. EX 1 at 11. Dr. Lorman testified that his exam of Claimant was noteworthy in that he had no muscle spasm, normal gait, normal sensation, normal muscle strength, normal reflexes, and no evidence of atrophy or muscular weakness. TR at 128. Dr. Lorman diagnosed chronic low back strain, thoracolumbar scoliosis, osteoarthritis in the lumbar spine, and degenerative disc disease in the lumbar spine. EX 1 at 11. Dr. Lorman stated, "In reviewing the examination at the time of today's office visit, which is 6 months shy of 19½ years since the patient's back injury, the only worsening noted is not in the patient's objective findings but rather in the patient's subjective complaints." EX 1 at 11. He noted that Claimant's condition and diagnosis of chronic back strain with some degenerative changes in the lower lumbar spine "mirror the findings noted in 1983." EX 1 at 12. Dr. Lorman noted that Claimant was then 61 years old and had been 41 at the time of his injury, and stated, "One could state with a high degree of surety, based upon the clinical examination, x-rays, and record review, that the worsening noted in the patient's subjective complaints is the result of the natural aging process." EX 1 at 12. He further opined, "It is felt that even in the absence of an injury occurring on 10/3/83, the patient would be experiencing low back pain and the back pain would progress with the passage of time, which is a function of the normal aging process." EX 1 at 12.

On March 21, 2003, Ms. Nedra Meyers, Employer's vocational expert, conducted a vocational evaluation. EX 6 at 315. Claimant perceived his own physical limitations as only being able to sit comfortably for 10 minutes, stand comfortably for 5 minutes, walk 30 minutes, and drive 60 minutes. EX 6 at 317. He described that he is not able to bend without pain, climb, maintain balance, or reach overhead. EX 6 at 317. He denied any problems with grasping, but indicated that problems with fine manipulation in that his left hand goes numb when writing. EX 6 at 317. He stated that he is able to complete daily living activities, including driving, bathing, walking, cooking, washing dishes, making beds, washing clothes, shopping, reading, and running errands. EX 6 at 318. On a scale of 1 to 5, Claimant stated his desire to return to work was a 0, and he believed he could not work with his present physical condition. EX 6 at 319. She also wrote that Claimant did not take the credit and collections position that he was offered after his training course in 1986 because it was an hour drive, which he did not believe he could do. EX 6 at 319. Claimant's employment history included working for Sea-Land as a driver for 11 years prior to his injury in 1983, working for Unique Foods as a truck driver for 10 years before that, and working various jobs before that, mostly in driving and delivery. EX 6 at 320.

Also on March 21, 2003, Ms. Meyers provided a labor market survey for Claimant. EX 6 at 305. Ms. Meyers considered positions in service occupations, focusing on those where a mature worker is preferred and which fit his education, skills, and physical restrictions. EX 6 at 306-07. She stated, "His hiring is directly related to his enthusiasm for work and how well he presents himself to a new employer." EX 6 at 306. She opined that Claimant's training for credit and collections clerk positions in 1986 had failed because Claimant was not trained in typing and he had turned down a position due to the low wages offered. EX 6 at 306-07. She also noted that Claimant had done various jobs since his 1983 injury, including welding and

construction. EX 6 at 307. Ms. Meyers identified positions in Claimant's geographic area that fit his skills and restrictions. EX 6 at 308. These positions included a Port-a-Potty service person, an auto garage route service person, a dispatcher, a ticket agent, a security guard, an interviewer, and an optical assistant. EX 6 at 309-314. Claimant did not pursue any of these jobs. TR at 52. It should be noted that since the 1988 decision, Claimant has never looked for any jobs and has not worked for wages. TR at 46, 51-52. However, he testified that until he moved 4-6 months before the hearing, he provided babysitting care for his grandson (his daughter's son) 2-3 times a week for 4-5 hours a day, which involved fixing lunch and occasionally taking him to the park. TR at 48-49, 50-51.

On March 31, 2003, Dr. Capen issued a "Supplemental Report" after having viewed the surveillance tapes from March 14, 16, and 20, 2002 and having reviewed the report of Dr. Peter Lorman from March 20, 2003. CX 8 at 47. Dr. Capen observed that the tapes showed "nothing repetitive or heavy being performed" and that "[a]ll of the activities were carried out for very short periods." CX 8 at 50. Thus, there was "nothing in the video that would contradict any of the statements [Claimant] made," and Dr. Capen found no reasons to change his prior opinions of Claimant's disability. CX 8 at 50-51. Dr. Capen disagreed with Dr. Lorman's report opining that Claimant would experience low back pain anyway due to the normal aging process. Citing the EMG findings of chronic right and left L4 and L4 radiculopathy and Claimant's limited mobility, Dr. Capen opined that Claimant's "symptomatology today is all due to the effects of his industrial injury of October 3, 1983 and not 'the normal aging process.'" CX 8 at 51.

On August 13, 2003, Claimant wrote to his attorney, Mr. Baker, in response to Ms. Meyers' March 2003 vocational evaluation and labor market survey, contesting some of her statements and opinions. EX 6 at 332. He expressed that he did not want to take the 1986 training course at all and wanted to quit after the instructor was hostile to him because of his need to move about during class to deal with his pain. EX 6 at 334. Claimant stated that he had been offered a credit and collections position, to which he had been referred by the instructor, but he could not accept it because it was an hour drive and the wages were not high enough to justify relocating or to compensate for his car and child problems at the time. EX 6 at 335. Claimant also stated, "I could not servive [sic] on nine dollars or ten dollars an hour. How enthusiastic is that, and confidence has nothing to do with it. If the company that I was employed with had done right be me when I had my first and second injury due to their company policies, I could have retired from my chosen employment at a much higher rate of pay." EX 6 at 336. Claimant then listed all of the sports and hobbies he could no longer participate in due to his disability. EX 6 at 337. He stated, "You think a entry job at minimum wage can be sufficient for my confidence? Thats like suicide." EX 6 at 337. Claimant also testified at the hearing that does not think he could adequately perform any of the jobs identified by Ms. Meyers due to pain and difficulty walking and using his left hand. TR at 40, 53.

On September 10, 2003, Ms. Meyers completed another labor market survey. EX 6 at 323. Her evaluation of Claimant's skills and employability remained essentially the same as in her March 2003 report, but she added that Claimant had some additional skills from having volunteered to help a friend with a catering truck in 1984. EX 6 at 324; EX 2 at 128. Ms. Meyers again identified positions, including various phone surveyor/interviewer positions and various cashier positions that were in Claimant's geographic area and fit his education, skills,

and restrictions. EX 6 at 325-31. On September 30, 2003, Ms. Meyers submitted an addendum, in which she provided the wages for the positions in 1983 dollars. EX 6 at 338-39.

On September 12, 2003, Claimant was evaluated by Dr. Andrew Jarminski, M.D., in Dr. Capen's office, and a progress report was issued. EX 3 at 248.4; EX 7 at 350; CX 8 at 53. This was the first time Claimant he been to Dr. Capen's office since February 2002. Dr. Jarminski noted that Claimant "has such pronounced left lower back pain with radiation to the lower extremity that he has been using a cane with his left hand." CX 8 at 54. He also noted that Claimant was having severe left hand pain such that he was unable to write more than a sentence or two. CX 8 at 54. Claimant was given an injection for pain. CX 8 at 54. Dr. Jarminski also ordered X-rays, which showed degenerative changes throughout the C5-C6 area, osteophytosis, levoscoliosis, and degenerative changes at the L4-5 and L5-S1 levels with facet hypertrophy present. CX 8 at 55. Dr. Jarminski diagnosed cervical discopathy, lumbar discopathy, chronic mechanical spine pain, and left carpal tunnel syndrome ("CTS"). CX 8 at 55. Dr. Jarminski arranged for Claimant to return to physical therapy three times a week, since he had been making some progress. EX 3 at 248.5, 248.7; CX 8 at 55. He also prescribed some medications, and referred Claimant to Dr. Steven Waldman for pain management. CX 8 at 55. Dr. Jarminski also ordered an MRI and an EMG/nerve conduction study of the upper and lower extremities to evaluate the radiculopathy in the lower extremities and the carpal tunnel, which had been overlooked previously since Claimant had not complained of it before. EX 3 at 248.6; CX 8 at 55.

On September 18, 2003, Dr. Lorman responded to Ms. Meyers' September 10, 2003 Labor Market Survey, and opined that there was no objective basis that would preclude Claimant from carrying out the duties for the positions described. EX 6 at 340-48.

At the request of Dr. Capen, an MRI was conducted on September 18, 2003 and was analyzed by Dr. Nancy Keroles. CX 8 at 59. The impression was mild right neural foraminal narrowing at the C3-4, mild left neural foraminal narrowing at C4-5, moderate left neural foraminal narrowing at C5-6, and bilateral uncovertebral osteophytes at C6-7 with left fact hypertrophy, causing mild narrowing of the right neural foramen and moderate narrowing of the left neural foramen. CX 8 at 60.

On September 23, 2003, Claimant's vocational expert, Ms. Kathryn Melamed, reviewed a report by Employer's vocational expert, Ms. Nedra Meyers, dated March 17/18, 2003. CX 12. Ms. Meyers had identified seven positions that she believed would be appropriate for Claimant, but Ms. Melamed determined that none of the positions would be suitable because they were either too strenuous or required education or skills that Claimant did not have. CX 12 at 3-9. Ms. Melamed noted that Claimant's worsening left extremity and carpal tunnel problems further limited his ability to perform positions requiring writing, typing, reaching, grasping, and other similar functions. CX 12 at 3, 9. Ms. Melamed also noted that Claimant had developed a "bowel control problem that he has been experiencing that appears to surface when he overly exerts himself or when he experiences back pain," which would further limit his ability to find employment. CX 12 at 9. She concluded that Claimant was not able to "compete in the open labor market for suitable alternative employment due to his current work restrictions and lack of marketable skills." CX 12 at 9.

On September 25, 2003, Dr. Capen issued a Supplemental Report in response to questions from Carrier regarding the injections administered for increased cervical spine and left upper extremity complaints. CX 8 at 61; EX 7 at 359. Dr. Capen opined, "These complaints are longstanding and should in all probability be attributed to the use of a cane for many years." CX 8 at 61; EX 7 at 359. He noted that Claimant had been using a cane for mobility due to his low back condition, but that he had reduced his use due to problems with his left arm and neck. CX 8 at 62; EX 7 at 360. He admitted that, although the earlier EMG studies were consistent with CTS, he had overlooked this condition because his primary focus had been Claimant's spine and Claimant had not complained about his left arm. CX 8 at 62; EX 7 at 360.

On September 26, 2003, Dr. Jarminski, on behalf of Dr. Capen, examined Claimant and issued a Progress Report. CX 8 at 63; EX 7 at 361. Dr. Jarminski stated, "On today's visit, it is clear that Mr. Ray has developed these left upper extremity problems as a result of using his walking cane which he used to help support him due to his lower back pain. Thus, all treatment related to the left shoulder and left upper extremity should be admissible on an industrial basis and treated as such." CX 8 at 64; EX 7 at 363. Dr. Jarminski also ordered an EMG and MRIs to further evaluate this condition. CX 8 at 64; EX 7 at 363.

AN MRI of the left shoulder and an MRI of the lumbar spine were conducted on October 6, 2003 and were analyzed by Dr. Keroles. CX 8 at 66-67; EX 7 at 354-56. The MRI of Claimant's left shoulder showed tendinosis of the supraspinatus tendon without tear, and acromioclavicular joint hypertrophy abutting the supraspinatus muscle. CX 8 at 66; EX 7 at 356. The MRI of Claimant's lumbar spine showed a 3mm posterior disc bulge at L4-5 with bilateral facet hypertrophy causing bilateral recess narrowing, and a 2mm posterior disc bulge at L5-S1 with bilateral facet hypertrophy and no spinal stenosis or neural foraminal narrowing. CX 8 at 67-68; EX 7 at 354-55.

On October 14, 2003, the EMGs requested by Drs. Jarminski and Capen were conducted and analyzed by Dr. Mette Hansen. CX 8 at 69; EX 7 at 365. Dr. Hansen noted that Claimant complained of increased cramping and difficulties in using his hands, especially his left hand, as well as radiating low back pain into his left leg and numbness in his right leg. CX 8 at 70; EX 7 at 366. With regard to the EMG testing of the upper extremities, Dr. Hansen stated that the findings were most consistent with moderate left CTS and mild right CTS. CX 8 at 72; Ex 7 at 368. The findings from the EMG of the lower extremities were most consistent with chronic bilateral L4-5 radiculopathies. CX 8 at 73; Ex 7 at 369.

On October 16, 2003, Dr. Capen evaluated Claimant and issued a progress report. CX 8 at 79; EX 7 at 375. He noted that Claimant was "not able to tolerate his pain at this time." CX 8 at 80; EX 7 at 376. Dr. Capen diagnosed cervical discopathy, lumbar discopathy, chronic mechanical spine pain, compensatory left shoulder impingement, and compensatory left CTS. CX 8 at 80; EX 7 at 376. It was recommended and agreed that Claimant would undergo carpal tunnel release surgery, but Dr. Capen cautioned, "There is a high likelihood that this patient will require multiple surgical interventions." CX 8 at 81; EX 7 at 377. He also referred Claimant to

Dr. Vincent Valdez for lumbar epidural blocks, scheduled a lumbar spine MRI, and prescribed medications for symptom relief. CX 8 at 81; EX 7 at 377.

Dr. Capen sought authorization for Claimant's left carpal tunnel release procedure on October 16, 2003. CX 8 at 92. This was denied by Carrier, and Dr. Capen objected in a letter on December 3, 2003. CX 8 at 89. Although Claimant wanted the carpal tunnel release surgery and Dr. Capen's office continued to seek authorization through January 2004, authorization was never provided. CX 9 at 98; EX 7 at 385; CX 8 at 95-96; TR at 39.

A lumbar spine MRI, which was ordered by Dr. Capen, was conducted on October 22, 2003 and analyzed by Dr. Keroles. CX 8 at 83-84; EX 7 at 357. It showed right facet and ligamentous hypertrophy at L3-4 indenting the lateral aspect of the thecal sac, diffuse posterior disc bulge at L4-5 with bilateral facet hypertrophy causing bilateral recess narrowing, and posterior disc bulge at L5-S1 with bilateral facet hypertrophy. CX 8 at 83-84; EX 7 at 357-58.

By letter dated November 25, 2003, Dr. Lorman explained that he did not evaluate Claimant for left CTS because Claimant's complaints had been "confined to the thoracic spine and lumbar spine." EX 1 at 13.1. Dr. Lorman opined, "It does appear that the complaints of a left carpal tunnel syndrome arose as an afterthought." EX 1 at 13.1. Dr. Lorman questioned some of Dr. Capen's diagnoses, including the diagnosis of left shoulder impingement and the diagnosis of cervical discopathy, on the basis that Claimant had only complained to Dr. Lorman about his "thoracolumbar spine." EX 1 at 13.2. Dr. Lorman also noted that the electrodiagnostic studies that apparently showed carpal tunnel syndrome and chronic radiculopathy had been conducted by one of Dr. Capen's in-house physicians, which Dr. Lorman felt was a "definite conflict of interest." EX 1 at 13.2. He stated that on the basis of Claimant's normal or negative test results, one would be unable to make diagnoses of CTS or shoulder impingement. EX 1 at 25. Dr. Lorman also questioned the opinion that the use of the cane had caused Claimant's cervical and left upper extremity complaints, because "when the patient was seen in this office, he was able to ambulate quite well without use of a cane." EX 1 at 13.2. Dr. Lorman repeated his initial diagnosis of chronic strain to the lumbar spine and degenerative disc disease. He also stated that Claimant had "thoracolumbar scoliosis on a developmental level, probably causing a large portion of the osteoarthritis." EX 1 at 13.3. He also opined that Claimant's osteoarthritis was "unrelated to the 1983 incident, but rather due to the natural aging process." EX 1 at 25. Finally, Dr. Lorman found that Claimant was permanent and stationary, and capable to returning to his usual work. EX 1 at 25-26.

On November 25, 2003, Claimant was evaluated by James Gray, Physician Assistant – Certified, in Dr. Capen's office. CX 8 at 85; Ex 7 at 379. Claimant's symptoms, diagnoses, and treatment recommendations, and disability status remained unchanged. CX 8 at 86; Ex 7 at 380.

On February 11, 2004, Claimant was evaluated by Dr. Jarminski in Dr. Capen's office evaluated Claimant and found him to be "quite symptomatic." EX 7 at 385. He reiterated his previous diagnoses and also diagnosed depression and anxiety. CX 8 at 98; Ex 7 at 385.

On February 19, 2004, Claimant was evaluated by Dr. Sean Leoni, M.D., a qualified medical examiner. EX 7 at 387. The purpose of the exam was to "rule out any heart disease"

due to Claimant's left arm pain. EX 7 at 388. Dr. Leoni found that Claimant had an abnormal echocardiogram and a possibility of coronary artery disease, for which he should immediately seek medical care. EX 7 at 390-91. However, Dr. Leoni noted that these heart problems were unrelated to the orthopedic injuries sustained during the course of his employment. EX 7 at 390.

On February 23, 2004, Claimant was evaluated by Ronald D. Farran, M.D., a neurologist, who conducted EMG and NCV tests. EX 8 at 432. On March 28, 2004, Dr. Farran issued a report to attorney Frank Hugg, in which he stated that the EMG results were "evidence for a mild to moderate left carpal tunnel entrapment, demyelinating type" and that there was "no evidence of an associated polyneuropathy although the absent sural sensory latencies suggest a possible underlying sensory neuropathy." EX 8 at 435. Dr. Farran testified that in his testing he did not find any atrophy or fasciculations that would have indicated ongoing nerve damage, and that the EMG was negative for nerve root compression. TR at 278-285. The only abnormality he found was changes in the paraspinus muscles of the lumbar spine due to a irritation of the nerve branch that comes into those muscles, which does not by itself substantiate nerve root problems. TR at 283-84. Dr. Farran also noticed that Claimant had calluses, which were "predominantly on the heel of the hand and at the metacarpal phalangeal joints, but not in the palm of the hand." TR at 276. However, Dr. Farran did not mention the calluses until his next report. TR at 277.

On March 8, 2004, Claimant returned to Dr. Lorman for a Complex Qualified Medical Reevaluation for Cervical, Thoracic, and Lumbar Spinal Pain. EX 1 at 14. Dr. Lorman noted complaints of cervical spine pain radiating to the base of the skull, thoracic spine pain radiating to the left upper extremity, and lumbar spine pain radiating to the lower extremities with numbness in the left foot. EX 1 at 15. At the hearing, Dr. Lorman emphasized that this was the first time that Claimant had complained to him about neck or cervical spine pain. TR at 140. On examining the cervical spine, Dr. Lorman found that all of the objective parameters were within normal limits but that Claimant had some tenderness and some restricted motion. TR at 140. X-rays conducted at the time of the visit showed osteoarthritis at the C5-6 level. EX 1 at 24. Dr. Lorman diagnosed strain to the neck, osteoarthritis of the cervical spine at C5-6, thoracolumbar scoliosis, chronic low back strain, and degenerative disc disease in the lumbar spine. EX 1 at 24; TR at 140. He found no evidence of herniated cervical or lumbar disc. EX 1 at 24. Dr. Lorman stated, "one is simply amazed how an injury that is 20 years old would require ongoing physical therapy, particularly therapy 3 times a week in the office of the attorney-appointed physician, Dr. Capen." EX 1 at 24. Dr. Lorman also stated, "based upon normal sensation and no evidence of median nerve compression, one would be unable to make a diagnosis of carpal tunnel syndrome." EX 1 at 25. He also stated, "One would be unable to make a diagnosis of an impingement syndrome of the left shoulder based upon a negative MRI scan." EX 1 at 25. He said Claimant "has evidence of some osteoarthritis involving the C5-6 level of the cervical spine which is a longstanding condition, unrelated to the 1983 incident, but rather due to the natural aging process. Dr. Lorman repeated his opinion that Claimant was permanent and stationary, and that only his subjective complaints had worsened, not his physical condition. EX 1 at 24-25.

On March 11, 2004 and April 9, 2004, Dr. Jarminski again evaluated Claimant and issued a progress reports indicating that Claimant's symptoms, diagnoses, and treatments, and disability status remained unchanged, and he continued to await authorization for the carpal tunnel release and for a cervical discogram study. CX 8 at 101, 105; EX 7 at 394.

Dr. Warren Procci and Dr. Hastings examined Claimant on March 15, 2004 as a Qualified/Agreed Medical Evaluator and issued a report on April 5, 2004. EX 8 at 436; CX 10. Dr. Procci noted Claimant's chief complaints as "musculoskeletal pain, sexual dysfunction, urinary and bowel urgency" and "depression, anxiety, sleep disturbance." CX 10 at 2. It should be noted that the urinary and bowel symptoms were explicitly denied in Dr. Capen's reports. Claimant was diagnosed with "Major Depressive Disorder, Single Episode, Moderate." CX 10 at 15. Dr. Procci found that psychiatric treatment, including psychotherapy and psychotropic medication consultation, "were reasonably required to relieve the effects of the work-related injury." CX 10 at 17. He was found to be permanent and stationary from a psychiatric perspective. CX 10 at 16. Dr. Procci stated, "The distress which is evident today developed as a direct result of the cumulative musculoskeletal and other physical injuries Mr. Ray sustained in the course of his employment with Sea-Land Services. Absent the industrial injuries and their sequelae, there is no reason to believe that he would today present with the ratable psychiatric disability now evident. Therefore, I find no basis for apportionment to any nonindustrial factors." CX 10 at 17. Dr. Procci also opined, "In the past, the momentum of his life, raising his children, as a single parent, in all likelihood propelled him forward. Now that his children are raised, he has more time to ruminate about the changes and losses in his life stemming from the industrial injuries. He perceives few realistic alternatives available to him at his age and at this point in his life [.]" CX 10 at 14-15.

Following the March 15, 2004 evaluation, Herbert Blaufarb, Ph.D., and Dr. Bloch, associates of Dr. Procci, issued a Supplemental Report, opining "that the causation of the patient's permanent psychiatric disability is 100 % attributable to the injuries he sustained during the course of his employment, and their sequelae." CX 10 at 25; EX 6 at 349.6.

On April 12, 2004, Dr. Farran conducted a defense neurological exam. EX 8 at 437. Claimant's complaints included low back pain radiating to the left side, numbness and weakness in the left foot and hand, burning pain in the left foot, and cervical pain. EX 8 at 439. Dr. Farran conducted an EMG and a Nerve Conduction Time study. EX 8 at 441. His impressions were low back strain with residual low back pain caused by the injuries in 1973, 1977, and 1983; mild to moderate left carpal tunnel entrapment syndrome of the demyelinating type; and degenerative disc and joint disease of the lumbar spine which was nonindustrial. EX 8 at 442. Dr. Farran contested the EMG interpretation by Dr. Hansen in August 2001, stating that Dr. Hansen "overstates the degree of entrapment and the presence of radiculopathy at the cervical and lumbar levels." EX 8 at 443. In contrast, Dr. Farran found no evidence of cervical or lumbar radiculopathy and evidence of only left CTS. EX 8 at 443. Dr. Farran stated, "Since Mr. Ray remained stable for approximately 21 years after his 1983 injury, and since his examination at this time is essentially no different, the only change then is the presence of new symptoms and increased symptomatology without objective change." EX 8 at 443. Dr. Farran opined that Claimant's complaints, including the increased cervical and lumbar pain and the CTS, are the result of the natural progression of the aging process and not his 1983 injury. EX 8 at 443. Dr. Farran found that there was no need for additional pain management. EX 8 at 444. Dr. Farran again noticed, and now noted in his report, Claimant's calluses, which were mostly on the heel of

his hand, his metacarpal joints, and his fingers. TR at 292-94. By observing how Claimant used the cane with his wrist somewhat extended and the handle resting in the palm of his hand, Dr. Farran concluded that the cane was not responsible for the calluses because they were more in the heel and fingers than in the palm. TR at 294.

On May 4, 2004, Dr. Capen issued a supplemental report, responding to the QME performed by Dr. Lorman on March 4, 2004. CX 8 at 109; EX 7 at 396. Dr. Capen challenged the assertions that Claimant did not have CTS, shoulder impingement, or neck problems related to his work injury and that he could return to work. CX 8 at 110; EX 7 at 398.

On May 13, 2004, Dr. Capen evaluated Claimant and issued a progress report. CX 8 at 113; EX 7 at 404. Dr. Capen reviewed a report from Drs. Procci and Blaufarb, who had diagnosed depressive disorder on March 15, 2004. CX 8 at 114; EX 7 at 405. Claimant's symptoms, diagnoses, treatment recommendations, and disability status were unchanged, except that Dr. Capen prescribed a left wrist splint. CX 8 at 115; EX 7 at 406.

On May 22, 2004, Dr. Marvin Klemes, M.D. conducted a Comprehensive Medical-Legal Evaluation, which consisted of a comprehensive psychiatric history, mental status examination, review of medical records, and administration of four psychological tests. EX 9 at 465. Dr. Klemes noted that Claimant used a cane that day. EX 9 at 467. Claimant expressed feeling "broken physically," and sad due to his not being able to work and do sports as before and due to his reduced sexual ability. EX 9 at 469. However, Claimant repeatedly denied having any psychiatric problems. EX 9 at 469-470. Claimant stated that he became divorced from his wife at age 43. EX 9 at 471. The psychological tests revealed a minimal degree of symptomatology suggestive of a possible depressive disorder or anxiety disorder and unlikelihood that Claimant was attempting to malinger or exaggerate cognitive defects. EX 9 at 473-74. Dr. Klemes reviewed all of Claimant's medical and psychiatric treatments and evaluations from 1983 to the present, focusing in particular on the report of Dr. Procci and Dr. Hastings from March 15, 2004. EX 9 at 474-527. Dr. Klemes concluded that Claimant does not have any psychiatric diagnosis that would prevent him from working. EX 9 at 529-32. He contested the diagnosis of Drs. Procci and Blaufarb, stating "it appears the psychologists have a slanted, biased opinion tending to exaggerate subjective findings in order to make Mr. Ray appear 'sick,' when in reality he is not ill from a psychiatric perspective." EX 9 at 529. Dr. Klemes discussed shortcomings and flaws of the specific psychological tests used by Drs. Procci and Blaufarb. EX 9 at 530-532.

On June 18, 2004, Dr. Jarminski evaluated Claimant and issued a progress report, noting that Claimant was "very symptomatic," and that "there is continued left hand carpal tunnel symptomatology that persists with a positive Tinel's sign and Phalen's test. Grasping is painful and weakened in comparison to the right hand wrist….He does use a cane." CX 8 at 119; EX 7 at 409. Claimant was to have a consultation with a pain management program for epidural injections. CX 8 at 119; EX 7 at 409.

Claimant was seen by Dr. Capen and others in his office on August 27, 2004; October 12, 2004; November 19, 2004; February 3, 2005; April 15, 2005; and May 27, 2005, and progress reports were issued. CX 8 at 122; EX 7 at 411; CX 8 at 127; EX 7 at 415; CX 8 at 130; EX7 at 418; CX 8 at 135; EX 7 at 422; CX 8 at 149. Claimant's symptoms, diagnoses, and treatment

recommendations, and disability status remained essentially unchanged, and they continued to await authorization for carpal tunnel release, discograms, and epidural injections. CX 8 at 123; EX 7 at 412; CX 8 at 128; EX 7 at 416; CX 8 at 131; EX 7 at 419; CX 8 at 136; EX 7 at 423.

On March 17, 2005, Claimant was evaluated by Dr. Jarminski and a progress report was issued. CX 8 at 139; EX 7 at 425. He also noted that Claimant "asked multiple questions today regarding low back surgery." CX 8 at 140; EX 7 at 426. He stated, "It is very likely that he is going to need further treatment, not only on his wrist in the form of carpal tunnel release, but also very likely surgery for the low back." CX 8 at 141; EX 7 at 427.

On April 5-7, 2005, Claimant underwent surveillance, and was observed using a cane on one of the three days. EX 14; TR at 114-15.

On April 25, 2005, Dr. Lorman evaluated Claimant again and conducted a Complex Qualified Medical Reevaluation for Low Back Pain. EX 1 at 28. Dr. Lorman emphasized that Claimant's "complaints have varied from visit to visit, with today's office complaints being confined to the lower lumbar spine without there being any mention of cervical spinal pain or thoracic spinal pain." EX 1 at 29. Dr. Lorman diagnosed chronic strain of the lumbar spine with no evidence of herniated lumbar disc, and noted that Claimant had no complaints referable to the cervical spine or thoracic spine. EX 1 at 38. Dr. Lorman again questioned the diagnoses and treatment of Dr. Capen, stating "[e]ighteen years following the time of the injury, the patient was referred to the office of Dr. Capen who has carried out a multitude of tests trying to find some iota of abnormal objective pathology present." EX 1 at 38. Dr. Lorman stated that the EMG tests and MRI scans were normal, and that Claimant did not have any symptomatology to support a diagnosis of CTS, shoulder impingement, or cervical or thoracic spine problems. EX 2 at 38-38.1. Dr. Lorman again found Claimant permanent and stationary with regard to his industrial injury, and found no need for future medical care. EX 2 at 38.1-38.2. He stated, "Based upon a lack of abnormal objective pathology present, there is no objective basis to preclude the patient from carrying out all those work activities he was carrying our prior to 10/3/83." EX 2 at 38.1-38.2. Dr. Lorman also stated, "There is no indication that the patient has sustained a worsening of his symptomatology following the 1988" decision. EX 2 at 38.2.

On May 3, 2005, Ms. Meyers completed a second Vocational Evaluation, based on an interview that occurred on April 28, 2004. EX 6 at 349.1. Claimant had misunderstood the purpose of the evaluation and consequently, he had to have his attorney present and be reassured that he would not be forced to return to work. EX 6 at 349.2. Claimant complained that he was not able to write due to pain and cramping in his left hand and that he has severe low back pain radiating into his legs that requires use of a cane. EX 6 at 349.2. Claimant indicated he can sit for extended periods if he is allowed to shift, and Ms. Meyers noted that Claimant shifted at 5-12 minute intervals during the interview. EX 6 at 349.2. He expressed he has a short attention span due to his pain and the medications he takes. EX 6 at 349.3. The rest of Claimant's physical limitations remained generally the same. EX 6 at 349.3. Claimant expressed interest in joining the Longshore Checkers Union. EX 6 and 349.3. Ms. Meyers noted that Claimant does not know how to use computers and "does not wish to learn the skill." EX 6 at 349.3.

Based on the new vocational evaluation, Ms. Meyers completed another Labor Market

Survey on June 13, 2005. EX 6 at 349.5. She determined that based on Claimant's physical restrictions and his skills, he could only perform sedentary positions with minimal writing, only simple computer use, and lifting under 10 pounds, and that permitted standing and walking as needed. EX 6 at 349.8. The positions identified included various parking cashier positions, as well as positions as a phone surveyor, phone interviewer, switchboard operator, or appointment setter. EX 6 at 349.10-349.15.

On June 23, 2005, Dr. Lorman responded that there was no objective basis that would preclude Claimant from performing the duties of all of the jobs that were identified by Ms. Meyers in June 2005. EX 6 at 349.20. Around the same time, Dr. Farran also responded that Claimant could perform all of the positions identified. EX 6 at 349.22-349.29.

On June 23, 2005, Dr. Farran issued a Neurologic Defensive Reevaluation, based on an April 12, 2005 exam. EX 8 at 460.1. He noted that Claimant's current complaints included an increase in numbness in the left hand and foot; recent onset of throbbing pain in the right lower extremity; increased depression due to persistent symptoms; stabbing pain in the right low back; and occasional neck pain. EX 8 at 460.3-460.4. Dr. Farran noted that Claimant used a cane in the left hand and that that cane "primarily sits in the non-calloused region of the palm as he utilizes it." EX 8 at 460.4-460.5. His impressions were low back strain in 1973 and 1977, cervical and low back strain in 1983, mild to moderate left CTS of the demyelinating type, and cervical and lumbosacral spondylosis. EX 8 at 460.5. Dr. Farran repeated his opinions that Claimant's cervical and lumbar pain are due to the natural progression of the aging process and that his CTS is unrelated to the 1983 injury. EX 8 at 460.6. Dr. Farran agreed with findings that Claimant had a neuropathy and opined that the neuropathy could cause the carpal tunnel. Dr. Farran also opined that "there has been no substantial 'change of condition' that would preclude him from competing in the open labor market" and that Claimant could perform all eight jobs identified by Ms. Meyers. EX 8 at 460.6.

On June 24, 2005, Dr. Capen issued a supplemental report upon reviewing the April 25, 2005 report of QME Dr. Lorman. CX 8 at 153. Dr. Capen contested Dr. Lorman's opinion that Claimant's condition had not worsened since the 1988 case, stating "There are MRI scans which do indeed show worsening and the EMG studies obtained were positive for prior/chronic right C6 and C7 radiculopathies and prior/chronic left C7 radiculopathy." CX 8 at 154. Dr. Capen also emphasized that the CTS "is a derivative injury. He has had to use a cane due to his lumbar spine condition. This has resulted in stress and strain to his wrists leading to carpal tunnel syndrome." CX 8 at 155. Dr. Capen also stated, "With regard to age related changes, this 63 year old would be expected to have some non-industrial related changes. However, one also has to take into consideration that he has not worked since 1983. Therefore, I would only apportion 5% of his low back disorder to age-related changes." CX 8 at 155.

Trial Testimony

Claimant

Claimant testified that he has increased pain in his lumbar spine and difficulty with associated activities. TR at 26. Claimant testified that his lumbar spine pain in 1988 was bad,

but it is much worse now. TR at 65. He testified that his level of pain on a scale of one to ten was miniscule (one or two) in 1988 and is a three to four now. TR at 27. Claimant notes that he has always had good and bad days. TR at 31. However, he testified that his pain on his bad days is now a seven or eight, while it was a two or three before. He also stated that his bad days now occur three or four days a week. TR at 21-32; TR at 65-66. In addition to having good and bad days, Claimant notes that his lumbar spine pain has always varied by activity. He testified that he now can only sit or stand 30 to 45 minutes without having to change positions, while he didn't have that problem in 1988. TR at 29-30. Similarly, he claims he can only lift 15 to 20 pounds now without pain reaction, but could lift 25 to 30 pounds in 1988. TR at 30. He also asserts that he can only walk about a block without having to stop to rest to deal with back pain. TR at 27. However, Claimant conceded that his present lumbar spine symptoms are, for the most part, very similar to those that he suffered in 1988. TR 68-72. For example, his pain was always constant in 1988, and is still constant. TR at 26, 68. In addition, his back pain increased from standing, walking, and sitting too long in 1988, just as at present. TR at 27, 68.

Claimant also asserts that he has a new pain in left foot and leg radiating from his back that he did not have in 1988. TR at 26, 32. He claims that his pain radiated only to his right side before, but now radiates mostly to his left side and only occasionally to the right. TR at 32, 68-69. He testifies that this radiating pain is much worse than in 1988. TR at 33-34. Claimant describes his radiating left extremity pain as occurring daily or constantly, from a level of two to four in morning. TR at 32-33, 38-39. The pain is increased by walking excessively, standing too long, bending, stooping, lifting. TR at 33; 38-39. Claimant testified that he now limps to take weight off of left side, which he claims he did not do in 1988. TR at 34, 38. He asserts that this limp increases with being more active, standing, and walking. TR at 38.

Claimant also testified that use of a cane to accommodate his back injury causes pain in his neck, left arm, and left hand, and also causes his left hand to swell, cramp, and feel numb in certain areas. TR at 34-38. Claimant testified that writing and driving also cause pain and cramping in his left hand. TR at 37. Claimant testified that he started using cane in the early to mid-1990's to assist with walking. TR at 34, 58. He testified that no doctor had prescribed use of a cane, but that he has brought his cane to Dr. Capen's office. TR at 59-60. Although he testified that he first used the cane in 1994, Claimant later admitted that he was using a cane at the time he attended a vocational rehabilitation course in 1986, because he had recently been in traction in the hospital. TR at 56. He explained that he stopped using a cane shortly thereafter because he got better, and that he had used a cane for different reasons then. TR at 57-59. Claimant now uses the cane about two to three times per week when he is active, and about once a week when he is not active. TR at 97. Some weeks he does not use the cane at all. TR at 97. He does not need the cane as much when taking medication. TR at 58. Claimant asserts that he is left-handed and uses the cane with his left hand. TR at 37. However, Dr. Lorman's records from 2003 and Dr. Scarborough's records from 1983 and 1984 show he is right-handed. TR at 60-61; EX 1; EX 2 at 195, 206. Claimant testified that those doctors made a mistake, and that he throws with right hand, but eats, drinks, and writes with left hand. TR at 61-63.

Claimant testified that he currently takes medication for pain. TR at 40. The medications that he takes cause blurring, drowsiness, dizziness, and a little light-headedness, and they affect his driving ability due to effects on his judgment and reaction times. TR at 41-42.

Claimant receives $158.41 per week from the Special Fund as a result of the 1988 decision. TR at 47. He also receives $487.50 as a Teamster's pension. TR at 48. In addition, Claimant currently receives $1,332.00 a month in Social Security benefits, which he has been receiving since 1989. TR at 46-47. However, he admitted that his Social Security benefits would be reduced if he worked. TR at 48.

Dr. Capen

Dr. Capen opines that Claimant's physical condition has "on a steady progressive basis worsened." TR at 194-95. Dr. Capen's opinion is that the original injury "set up a process where that injury has deteriorated and worsened over the years." TR at 221. Dr. Capen stated, specifically, that over the four years that he has treated Claimant, his condition has worsened "[w]ith respect to the amount of spinal pain, the development of the shoulder impingement, the development of anxiety and depression" TR at 219-20.

Dr. Capen testified that he believed Claimant's use of a cane caused his carpal tunnel because the cane "pushes directly into the mid-palm, which is where the median nerve passes under the carpal tunnel and it is a susceptible point for nerve compression." TR at 208. Dr. Capen cited a study from Rancho Los Amigos dealing with use of walkers, canes, wheelchairs that he claims "substantiates that there is an increased incidence of shoulder problems and peripheral nerve compression," but conceded that there were no studies dealing with just canes. TR at 208, 226-227. Dr. Capen stated that "carpal tunnel is the main peripheral nerve compression problem that is directly linked with weight-bearing with the upper extremities." TR at 208. However, Dr. Capen has no explanation for why Claimant's carpal tunnel is on the left and right sides, but opined that it was not idiopathic bilateral CTS because it was not equal on both sides. TR at 260-61.

Dr. Capen conceded that he had noticed in his examinations that Claimant has particularly thick skin on his hands with calluses on the lower part of his fingers and in his palms. TR at 255. Dr. Capen believes that calluses are primarily due to use of the cane, unless Claimant is doing some other work that Dr. Capen does not know about, since his calluses from working in the 1970's and 1980's should have smoothed out by now. TR at 264-65. Dr. Capen demonstrated that a cane is used by gripping the handle, extending the wrist, and putting pressure on the palm. TR at 258-60. He testified that there is a correlation between Claimant's calluses and where he holds the cane, because "since you grip the cane, you'd expect calluses in the flexor creases of your fingers, along the metacarpal phalangeal joint" but suggested that Claimant may not have as many calluses in his palms because "for workers that use their hands a lot, the skin of their palm is thick." TR at 260.

Dr. Capen testified that Claimant had a mild cervical strain following the 1983 injury from which he recovered, but that he developed new cervical problems from use of the cane. TR at 235. He testified that Claimant's current neck pain is due to a combination of the original neck strain, use of a cane, and aging. TR at 253-54. He believed that the use of a cane caused

Claimant's cervical spine problems because the "cervical spine muscles and your shoulder muscles work in unison. They are both susceptible to the weight-bearing and eventually, yes, as you get progressive stress on a repetitive basis, it can cause cervical stress." TR at 208-09.

Dr. Capen links the use of the cane with the 1983 injury "[b]ecause the disk injuries, the spine structure injury in 1983, has progressed over time to have created the leg problems, the limping, and the fact that his gait is no longer normal and it necessitated the use of an assistive device for him to walk. The tradeoff would be to continually limp in a worse manner, which would further deteriorate and stress the lower lumbar disks and facet joints, and even have the risk of his leg giving way, causing falls. So it was a cane that was utilized to help support and bear some of his body weight through his upper extremity. And from that, he developed, in my opinion, the carpal tunnel, as well as the shoulder impingement." TR at 220-21.

Dr. Capen admitted that Claimant's condition may be permanent but his pain levels will wax and wane. TR at 263-64. Dr. Capen conceded that Claimant's subjective complaints have essentially waxed and waned, and that his subjective complaints in 2002 were similar to those documented in the medical records in the three years following the 1983 injury. TR at 232. Dr. Capen testified that if Claimant's condition remains the same and he continues to refuse surgery, there are only palliative treatments that can be used to help his flare-ups of neck and back pain, including water exercise, pain medications, home remedies (including a TENS unit or heat and ice), trigger blocks, and epidural blocks (which Claimant has refused).

Dr. Capen testified that Claimant was totally unable to work. TR 201. However, Dr. Capen conceded that Claimant theoretically could work at a part-time job that would allow him to sit or stand, as long as he had recovered from an acute flare up. TR at 229-30. Dr. Capen believed this based on surveillance video of Claimant being active four to five hours a day. TR at 230-31. However, Dr. Capen stated that Claimant has flare-ups two to three times a month that would completely prevent him from working for two to three days. TR at 263.

Dr. Lorman

Dr. Lorman opined that of Claimant's current conditions, only his chronic low back strain is related to the 1983 work injury. TR at 123. Dr. Lorman does not believe that Claimant has a need for surgery or invasive testing of his lumbar or cervical spine, because there is no nerve root compression. TR at 124, 148. Dr. Lorman testified that he could not ascertain any change in Claimant's medical condition based on comparison of the records from 1988 and his own evaluations. TR at 125, 149-50. Dr. Lorman opined that Claimant has chronic lumbar strain as opposed to nerve root compression of the spine, because all of the tests (MRI, CT scans, and clinical evaluation) were normal; rather he believes that Claimant's degenerative disc disease and osteoarthritis are causing his chronic lumbar pain. TR at 130-131, 139. In comparing Claimant's MRI and CT scans from 1983 to the present, Dr. Lorman finds them to show the same pathology, without any nerve root compression. TR 135-38.

Dr. Lorman opined that Claimant's occasional use of a cane could not aggravate his cervical spine condition because his cervical spine condition is a strain. TR at 142, 176. Dr. Lorman also stated that based on his experience as an orthopedist treating patients with carpal

tunnel including some who use canes, he did not see a causal relationship between the occasional use of a cane and development of CTS, since "[u]sually a carpal tunnel syndrome is caused by constant repetitive activity of the hand." TR at 143, 174. He emphasized that use of a cane does not involve repetitive motion. TR at 151-52. He opined that Claimant's CTS was idiopathic, meaning that it arose on its own with no identifiable cause. TR at 146.

Finally, Dr. Lorman opined that Claimant could work in sedentary positions, as long as the position did not involve lifting. TR at 149, 176.

Dr. Farran

Dr. Farran emphasized that there was no evidence of lumbar nerve root compression from the EMG testing. In comparing the MRI and CT scans from before the 1988 decision to those taken more recently, Dr. Farran found that they were "very similar" with no nerve root compression and that any changes were due to normal aging. TR at 301. Dr. Farran emphasized that only Claimant's subjective symptoms have changed.

Dr. Farran testified that there was no support for the argument that use of a cane causes CTS and has had no experience with such a cause in his practice. TR at 295. According to Dr. Farran, "Entrapment Neuropathies," by Dawson, the leading treatise, has no mention of use of a cane being connected to CTS. TR at 294-95. Dr. Farran further believes that use of a cane does not cause CTS because it is for balance, not weight-bearing. TR at 304. Dr. Farran also testified that he believes Claimant's calluses are residual from his prior work activities and not due to use of the cane, because Claimant does not use the cane for weight-bearing and holds it in a different place than where the calluses are located. TR at 304. Dr. Farran also compared the EMG tests from 2001 and 2003 and concluded that Claimant actually improved. TR at 297-98. Dr. Farran believes that Claimant's CTS does not require surgery because he is improving, there is no denervation or muscle abnormality, and it is not bad enough to warrant the risk. TR at 302, 316.

CONCLUSIONS OF LAW

These findings of fact and conclusions of law are based on my observation of the appearance and demeanor of the witnesses who testified at the hearing and upon the analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. In arriving at a decision in this matter, I am entitled to determine the credibility of witnesses, to weigh the evidence, and to draw my own inferences from it; furthermore, I am not bound to accept the opinion or theory of any particular medical expert. *See Banks v. Chicago Grain Trimmers Assoc., Inc.,* 390 U.S. 459, 467, *reh'g denied,* 391 U.S. 929 (1968); *Todd v. Shipyards Corp. v. Donovan,* 300 F.2d 741, 742 (5th Cir. 1962); *Scott v. Tug Mate, Inc.,* 22 BRBS 164, 165 (1989); *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (1989); *Avondale Shipyards, Inc. v. Kennel*, 914 F.2d 88, 91 (5th Cir. 1988).

Credibility

Claimant

I find that Claimant was credible with regard to his current levels of pain and other complaints. Although Claimant was able to sit for extended periods of time of approximately two hours during the hearing, he did appear to be uncomfortable, which helps confirm his pain complaints. Because Claimant is not medically-trained, however, I do not find him credible with regard to his beliefs about the causes of his pain.

However, I do not find Claimant credible that his pain suddenly got significantly worse around 2001 when he started seeing Dr. Capen. I find that psychologists Dr. Blaufarb and Dr. Bloch present a more plausible explanation. In their March 15, 2004 report, they stated, "In the past, the momentum of his life, raising his children, as a single parent, in all likelihood propelled him forward. Now that his children are raised, he has more time to ruminate about the changes and losses in his life stemming from the industrial injuries." CX 10 at 13. Thus, it seems likely Claimant did not begin seeking medical care and pursuing modification in 2001 because his condition had worsened significantly, but rather because his children were about 18 and 21 at that time and leaving home, such that Claimant suddenly had more time and perceived urgency to pursue increased compensation. This is supported by the fact that the reports of Drs. Strazynski and Haddadzadeh indicate that Claimant continued to experience pain and mobility problems over the years after the 1988 decision, but his condition was largely unchanged. Similarly, Drs. Lorman and Farran opined that Claimant has only experienced gradual change in his condition over the years due to aging.

I also question Claimant's credibility with regard to his ability to work. First, although Claimant has done some volunteer work since the 1988 decision, including helping with a friend's catering truck and babysitting his grandson, he has made no effort to seek paid work during that time. He admitted at the hearing that his Social Security benefits would be reduced if he worked. TR at 48. In addition, on August 13, 2003, Claimant wrote to his attorney, Mr. Baker, in response to Ms. Meyers' March 2003 vocational evaluation and labor market survey, indicating that he would not be willing to take certain jobs because the pay was not high enough and that doing an "entry job at minimum wage" would be like suicide for his confidence. EX 6 at 332-37. In contrast, Claimant expressed interest in joining the Longshore Checkers Union. EX 6 and 349.3. Moreover, I note that since the 1988 decision, Claimant has never looked for any jobs, but has been able to complete activities of daily living, raise and home-school his children, baby-sit his grandson, and volunteer to help a friend with a catering truck. TR at 46, 48-49, 50-52. For all of these reasons, I find that Claimant is not credible when his asserts that he is completely unable to work.

Dr. Capen

Dr. Capen is board certified in orthopedic surgery by the American Board of Orthopedic Surgery. He is also a member of the North American Spine Society and a member/diplomat of the American Academy of Orthopedic Surgery. He is on the faculty of Rancho Los Amigos Medical Center as a Clinical Associate Professor, teaching orthopedic surgery, focusing predominantly on spine surgery. He has written a book and numerous articles about orthopedic surgery. He is a qualified medical examiner in the State of California. TR at 191-92.

As a preliminary matter, the record shows that a series of correspondence, beginning as early as October 1990, between Claimant; Claimant's attorney, Mr. Baker; and his former physician, Dr. Strazynski, trying to obtain a diagnosis that would enable them to seek a modification to increase Claimant's compensation. EX 2 at 110. This suggests that Claimant's (and his attorney's) ultimate goal has long been to obtain increased compensation, and that he is willing to ask his doctor specifically for a diagnosis that will enable him to do so.

Claimant's attorney, Mr. Baker, notified the carrier, Crawford and Company, on June 26, 2001 that Claimant was electing to be treated by Dr. Capen. EX 3 at 218. However, Claimant did not actually see Dr. Capen until July 17, 2001. CX 8 at 1. This suggests that Dr. Capen was chosen by Claimant's attorney, rather than by Claimant himself. Consequently, the usual presumption of deference and credibility in favor of the treating physician due to his longstanding relationship with the claimant before any prospect of litigation is inapplicable to Dr. Capen in this case. Rather, it appears that Dr. Capen was enlisted at least for the purpose of obtaining more reimbursement for medical care, if not also for the purpose of preparing a case for modification. This conclusion is supported by letters in the record in which Claimant's attorney requested that Dr. Capen opine on specific question in light of an upcoming trial date. *See* EX 3 at 236-238. In addition, the record indicates that Dr. Capen missed or delayed in noticing certain symptoms and diagnoses, including Claimant's CTS and his bowel problems, which perhaps indicates that Dr. Capen was focused on finding compensable injuries rather than on treating what was actually ailing Claimant.

In addition, Dr. Capen operates four offices in the Los Angeles area, at which he works with six other physicians. TR at 235-35. On many visits to his office, Claimant was seen by various other physicians who work with Dr. Capen, such that Dr. Capen's opinions cannot all be based upon his own observation. Moreover, these other doctors gave opinions and diagnoses that were remarkably similar to those of Dr. Capen. Dr. Capen's in-house staff also conducted many of the objective tests, such as MRIs and EMGs, and gave impressions that aided the opinions of Dr. Capen, but which other doctors believed were not actually supported by the test results. For these reasons, I find the opinions and diagnoses of the other physicians and staff persons in Dr. Capen's office similarly not credible.

Finally, Dr. Capen's practice is 75% workers' compensation. TR at 235. In contrast, Dr. Lorman's practice is only three percent forensic, as he is a full-time orthopedic surgeon. TR at 143. Similarly, Dr. Farran's practice is less than five percent medical/legal work for workers' compensation or personal injury cases. TR at 268-69.

Based on all of the above reasons, I will give less credibility to Dr. Capen and more credibility to Drs. Lorman and Farran on most issues.

Dr. Lorman

Dr. Lorman is an orthopedic surgeon, who has been board certified since 1970. He is a diplomat of the American Academy of Orthopedic Surgery. He is an agreed medical examiner and qualified medical examiner under the California Labor Code. His practice is limited to orthopedic surgery, and he operates three to four times per week. TR at 120. He evaluated

Claimant three times for this case. TR at 121. I found Dr. Lorman to be a credible witness.

Dr. Farran

Dr. Farran is a neurologist. He did an electrodiagnostic fellowship at UCLA Harbor General for a year, and then taught there for several years before dedicating himself to private practice. He is board-certified as a diplomat in pain management by the Board of Neurology. Dr. Farran has special training and expertise in reading MRIs, and interpreting MRIs is an active part of his clinical practice. TR at 269-70. I found Dr. Farran to be a credible witness.

Modification

Section 22 of the Act provides:

> "Upon his own initiative, or upon the application of any party in interest…on the ground of a change in conditions or because of a mistake of fact by the deputy commissioner, the deputy commissioner may, at any time prior to one year after the day of the last payment of compensation …review a compensation case…and… issue a new compensation order which may terminate, continue, reinstate, increase or decrease such compensation, or award compensation." 33 U.S.C. §922.

Modification is permitted based on a mistake of fact in the initial decision or a change in the claimant's physical or economic condition. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291 (1995); *Dobson v. Todd Pacific Shipyards Corp.*, 21 BRBS 174 (1988). Modification based on a change in condition may be granted where a claimant's physical or economic condition has improved or deteriorated following entry of a compensation award. *Wynn v. Clevenger Corp.*, 21 BRBS 290 (1988). Once the moving party submits evidence of a change in condition or mistake in fact, the standards for determining the extent of disability are the same as in the initial proceeding. *See Rambo*, 515 U.S. at 296, 30 BRBS at 3(CRT); *Vasquez v. Continental Maritime of San Francisco, Inc.*, 23 BRBS 428 (1990).

The party requesting modification bears the burden of proof in showing a change in condition. *Vazquez v. Continental Maritime of San Francisco, Inc.*, 23 BRBS 428 (1990); *Winston v. Ingalls Shipbuilding, Inc.*, 16 BRBS 168 (1984). The section 20(a) presumption is inapplicable to the issue of whether a claimant's condition or earning capacity has changed since the prior award. *Leach v. Thompson's Dairy, Inc.*, 6 BRBS 184 (1977). In rendering his decision, the administrative law judge should consider both the old evidence and the newly submitted evidence. *Dobson*, 21 BRBS at 176.

In this case, Claimant was found in 1988 to be permanently partially disabled. Claimant brings this petition for modification based on change in his physical condition and change in economic condition. The Director, Office of Workers' Compensation Programs, in a letter dated June 22, 2005, takes no position with regard to modification.

a. Change in Physical Condition

According to Claimant, his physical condition has changed in five ways: 1) increased lumbar spine problems; 2) new condition in his neck/cervical spine; 3) new condition his left shoulder/arm; 4) carpal tunnel syndrome (CTS) in the left hand; and 5) depression and anxiety. ALJX 1 at 1-2.

1. Lumbar Spine

Claimant asserts that his lumbar spine condition has worsened in that he now experiences increased pain, reduced mobility, increased radiating pain to his lower extremities, and a pronounced limp. Claimant's physician, Dr. Capen, asserts that Claimant's condition has worsened in that he now has nerve root compression. In contrast, Employer asserts that Claimant's condition has not changed much since 1988 and any changes are due to the natural aging process, rather than the 1983 injury. Further, Drs. Lorman and Farran assert that there is no evidence of any nerve root compression.

The objective evidence does not show any change in Claimant's lumbar spine. Comparing the myelogram, CT scans, and MRIs from before the 1988 decision to those conducted after 2000, there is no change in Claimant's lumbar spine condition.
The December 2, 1983 CT scan showed "disc material posterior and posterior lateral on both the right and left side at L4-5 and L5-S1." EX 2 at 212. The April 24, 1984 myelogram showed "confirmed [the] initial CT scan findings of the defect of L4-L5 interspace." EX 2 at 147. The September 3, 1985 scan showed "considerable degeneration of the right facet and facet tropism" at L3-4, "minimal symmetrical annular bulge" at L4-5, and "some degeneration of the L5-S1 disc space without disc herniation and slight narrowing of the left neural foramen." EX 2 at 165. The August 30, 1986 MRI showed "evidence for the desiccation of the discs at L4-5 and L5-S1 with central bulging posteriorly at these interspaces. There is obliteration of the lateral recess on the left side at L4-5 by disc material with moderate stenosis of the right and left intervertebral foramina at this disc space." EX 2 at 137.

Similarly, the July 2000 MRI of the lumbar spine showed disc desiccation and mild disc space narrowing at L4-5 and L5-S1, small disc herniation at L4-5 and L5-S1, moderate to severe facet arthrosis, and neuroforaminal canal stenosis that was mild to moderate on the right and moderate to severe on the left. EX 2 at 78. The October 6, 2003 MRI showed "3mm posterior disc bulge at L4-5 with bilateral fact hypertrophy causing bilateral recess narrowing" and "2mm posterior disc bulge at L5-S1 with bilateral fact hypertrophy. No spinal stenosis or neural foraminal narrowing." EX 7 at 354. The October 22, 2003 MRI showed exactly the same thing as the October 6 MRI but also added an impression of "right facet and ligamentous hypertrophy at the L3-4 level indenting the lateral aspect of the thecal sac." EX 7 at 357.

In summary, although the labels used vary slightly, both before and after the 1988 decision, Claimant has had some small bulging (or herniation) at L4-5 and L5-S1, some narrowing (or stenosis) of the neuroforaminal canal at those spaces, and considerable facet degeneration (or facet joint hypertrophy, or facet arthrosis) at L3-4. As stated by Dr. Lorman, the "tests are very, very similar" such that they are "basically the same." TR at 135, 138. Thus, the objective tests do not show any change in Claimant's low back condition.

Moreover, the opinions of Drs. Lorman and Farran support the conclusion that there has been no objective change in Claimant's low back condition. On March 20, 2003, Dr. Lorman opined that "the only worsening noted is not in the patient's objective findings but rather in the patient's subjective complaints." EX 1 at 11. Similarly, Dr. Farran opined, "Since [Claimant] remained stable for approximately 21 years after his injury, and since his examination at this time is essentially no different, the only changes then is the presence of new symptoms and increased symptomatology without objective change." EX 8 at 443. Even Dr. Capen conceded that Claimant's condition may be permanent while his pain levels wax and wane. TR at 263-64.

The objective evidence similarly fails to show any evidence of nerve root compression. None of the objective tests above gives an impression of nerve root compression. The lack of a finding of nerve root compression from the objective tests is not conclusive, because Dr. Lorman emphasized that a clinical examination may reveal nerve compression that was not shown by an MRI. TR at 130. However, Dr. Capen, and his associates, provided the first and only diagnosis of nerve root compression. Further, I credit the testimony of Drs. Lorman and Farran over that of Dr. Capen that physical evaluations of Claimant do not provide support for a diagnosis of nerve root compression either. TR at 279-285. Further, the evidence regarding Claimant's calf measurements, which was cited by Dr. Capen in support of his diagnosis, is inconclusive and does not clearly support a diagnosis of nerve compression. TR at 237-244

Despite a lack of objective change in his low back condition, the parties agree, and I also find, that Claimant's low back pain and related subjective complaints have worsened. *See, e.g.,* TR at 174; EX 1 at 11. Since Claimant cannot establish a claim for modification based on objective change in his physical condition, the relevant inquiry is whether Claimant's increased low back pain is due to progression of his 1983 injury, deterioration due to his degenerative disc disease and aging, or both. The BRB has held that where a claimant has suffered only a permanent partial disability as a result of an accident arising out of and in the course of his employment, and where the rest of the deterioration in the claimant's physical condition was caused by degenerative changes unrelated to the accident, there is no "change in condition" warranting section 22 modification. *Rizzi v. Four Boro Contracting Corp.*, 1 BRBS 130 (1974). Thus, if Claimant's increased pain and other symptoms are unrelated to the 1983 work injury, there is no change in his low back condition for purposes of modification.

On March 20, 2003, Dr. Lorman opined, "One could state with a high degree of surety, based upon the clinical examination, x-rays, and record review, that the worsening noted in the patient's subjective complaints is the result of the natural aging process." EX 1 at 12. He further opined that "even in the absence of an injury occurring on 10/3/83, the patient would be experiencing low back pain and the back pain would progress with the passage of time, which is a function of the normal aging process." EX 1 at 12. Dr. Lorman believes that progression of Claimant's pre-existing osteoarthritis and degenerative disc disease is causing his current lumbar spine pain. TR at 130-31, 139. Dr. Farran similarly opined that that Claimant sustained a low back strain in 1983, but that his current back pain is due to the natural progression of the aging process and not his 1983 injury. EX 8 at 443, 460.6. As discussed above, I find Drs. Lorman

and Farran to be generally credible, and Dr. Capen not credible. Moreover, even if I did find Dr. Capen credible, he failed to give any persuasive arguments to refute the opinions of Drs. Lorman and Farran. CX 8 at 51, 110. More specifically, I find that the opinions of Drs. Lorman and Farran on the issue of causation of Claimant's increased low back pain are supported by the evidence. The pre-1988 doctor's reports and the 1988 decision itself demonstrate that Claimant's chronic low back strain from the 1983 injury had stabilized by the time of the 1988 decision. EX 1 at 4, EX 2 at 39.6. Given that Claimant has not done any work since the 1988 decision to aggravate his condition, I find it highly unlikely that his 1983 injury has reemerged on its own. Rather, the objective evidence demonstrates that Claimant had degenerative disc disease before the 1983 injury, which is a condition that progressively worsens over time.

For all of these reasons, I find that Claimant's increased low back pain is due to progression of his pre-existing degenerative disc disease and aging, not his 1983 injury.

2. Cervical Spine

Although Claimant had some cervical spine pain following his 1983 work injury, he recovered from that injury before the 1988 decision. He had no complaints, evaluation, or treatment to his cervical spine from February 1984 when he saw Dr. Roe until July 2000 when an MRI was conducted of his cervical spine. TR at 75. At the hearing, Claimant admitted that by February 1984 his neck pain from the original injury had subsided. TR at 73, 74. In 1993, Chiropractor Morris noted that Claimant denied any cervical pain. TR at 75.

Thus, since a change in condition since 1988 has been shown, it must be determined whether his current neck condition is caused by or related to the 1983 injury. Either Claimant's neck problems resolved completely before 1988 and his use of the cane, his gait, and/or his lumbar spine condition have caused the current neck problems to reemerge, or Claimant's current neck problems are completely unrelated to his 1983 injury and are caused instead by aging or some other factor. See TR at 322-23.

Dr. Capen testified that Claimant had a mild cervical strain following the 1983 injury from which he recovered, but that he developed new cervical problems from use of the cane. TR at 235. He testified that Claimant's current neck pain is due to a combination of the original neck strain, use of a cane, aging, and complications from his shoulder impingement. TR at 253-54. He explained that use of a cane causes neck problems because "your cervical spine muscles and your shoulder muscles work in unison [and] are both susceptible to the weight-bearing and eventually…progressive stress on a repetitive basis…can cause cervical stress." TR at 208-09.

In contrast, Dr. Lorman opined that Claimant's cervical problems are due to a strain, and there is no pathological reason how they could be caused by his use of a cane. TR 141-42. Dr. Lorman opines that use of a cane cannot physiologically caused cervical spine problems, and states that he has many patients with canes who do not have cervical problems as a result. TR at 176-77. Dr. Lorman does not believe that Claimant has had any neck problems over the last three years that are related to the 1983 injury. TR at 124.

Similarly, Dr. Farran does not think there is any connection between the use of a cane and

Claimant's cervical complaints. TR at 305. Based on his record review and evaluation of Claimant, Dr. Farran also testified that Claimant's neck/cervical spine is "about the same" as in 1988. TR at 305. Dr. Farran believed that Claimant had a sprain/strain in 1983 that stabilized, and that Claimant's current back problems are "mostly arthritic pain." TR at 317.

The only objective tests of Claimant's cervical spine are an MRI from July 6, 2000 (EX 2 at 76) and an MRI from September 18, 2003 (CX 8 at 59). These tests primarily show osteophytes caused by Claimant's osteoarthritis, which is due to aging. Moreover, the absence of tests of Claimant's cervical spine closer to the 1983 injury further reinforces that the original injury was merely a cervical strain, from which Claimant recovered relatively quickly. Thus, Claimant fully recovered from his original neck strain by 1984, and the recent objective tests fail to show the he has any problems other than those caused by aging.

For all of these reasons and those discussed below with regard to Claimant's use of a cane, I find that Claimant has failed to demonstrate a change in condition in his cervical spine related to his 1983 injury.

Use of the Cane

Claimant is not persuasive that use of a cane has caused his current cervical spine condition, left shoulder condition, or CTS.

First, Claimant says he only uses the cane a few times a week, if at all. Drs. Lorman and Farran are credible when they state that such infrequent use for short periods of time could not cause Claimant's conditions. Moreover, when he opined that Claimant's conditions were caused by use of a cane, Dr. Capen did not properly understand how often Claimant uses a cane. Dr. Capen understood that Claimant used the cane "a fair amount of the time," or "the majority of the time that he's up walking around," or "most of the time." TR at 257. After Claimant testified that he only uses the cane a few times a week at most, Dr. Capen conceded that Claimant's description of how often he uses the cane is "less" than what he previously understood. TR at 257.

Second, there is no research that connects use of a cane to CTS or cervical spine or shoulder problems. Even Dr. Capen testified that the only study possibly connecting cane use and CTS was a group study that also included walkers, crutches, and wheelchairs. I find that a cane is different from these other apparatuses in that it is not used as much for weight-bearing as crutches or walkers, and the hands and wrist are used much less repetitively with a cane than with a wheelchair. Moreover, compared to persons who must always use crutches, walkers, or wheelchairs to get around, Claimant uses his cane much less frequently.

Third, the cane is not used for weight-bearing. In asserting that he cane has caused Claimant's current neck, shoulder, and CTS conditions, Dr. Capen believes that the cane is used for weight-bearing. In addition, Claimant himself testified, "I weigh 264 pounds and I put a lot of weight on that arm and shoulder, when I'm using the cane." TR at 107. However, as stated by Dr. Farran, a cane is used for balance, not for weight-bearing. TR at 304. Moreover, Claimant's calluses do not match up with where he holds the cane, suggesting that he is not

exerting much pressure on his hand with the cane. Thus, I find that Claimant does not use the cane for weight-bearing enough to cause his conditions.

Thus, I find that because Claimant's use of a cane is infrequent and non-weight-bearing and because there is no evidence to support causation, I find that Claimant's use of a cane has not caused or aggravated his neck, shoulder, or CTS conditions.

3. Left Shoulder

As with the cervical spine, Claimant has shown that he did not have problems with his left shoulder in 1988. Thus, the next inquiry is whether Claimant's current left shoulder condition is related to or caused by the 1983 work injury.

On October 6, 2003, an MRI of Claimant's left shoulder was conducted and showed tendinosis of the supraspinatus tendon without tear, and acromioclavicular joint hypertrophy abutting the supraspinatus muscle. CX 8 at 66; EX 7 at 356.

Dr. Capen reported that the left shoulder MRI from October 6, 2003 showed bursitis and rotator cuff impingement, which he believes justify Claimant's complaints of pain and discomfort when using the cane. TR at 212-13. Dr. Capen further believes that Claimant's shoulder problem is due to use of the cane, which in turn, is tied to his back problems from the 1983 work injury. TR at 221, 207, 254. In support of this conclusion, Dr. Capen asserts that the study regarding the use of assistive devices, including canes, crutches, walkers, and wheelchairs, shows a connection with shoulder impingement. TR at 226.

In a letter dated November 25, 2003, Dr. Lorman noted that Claimant had not complained of any shoulder problems during his first visit and that the shoulder complaints he raised during the second visit seemed like an afterthought. EX 1 at 13.1-13.3. Dr. Lorman also stated that the October 6, 2003 MRI did not show any actual impingement and stated, "One would be unable to make a diagnosis of an impingement syndrome of the left shoulder based upon a negative MRI scan." EX 1 at 13.2, 25. Finally, on April 25, 2005, he stated that the EMG tests and MRI scans were normal, and that Claimant did not have any symptomatology to support a diagnosis of shoulder impingement. EX 2 at 38-38.1.

As discussed above, Claimant's use of a cane was too infrequent and non-weight-bearing to cause or aggravate his current shoulder condition. More specifically, Dr. Farran opined that there is no connection between use of the cane and Claimant's cervical spine complaints. TR at 305. Dr. Lorman stated that it is not physiologically possible for a cane to create a cervical spine problem. TR at 176. He also testified that periodic use of a cane could not aggravate or accelerate Claimant's cervical spine condition because it is due to a strain. TR at 142.

For all of these reasons, I find that Claimant has failed to demonstrate a change in condition with regard to any left shoulder condition related to or caused by his 1983 injury.

4. Carpal Tunnel Syndrome (CTS)

Claimant has shown that he did not have CTS in 1988. Thus, the next inquiry is whether Claimant's CTS is related to or caused by the 1983 work injury.

Claimant asserts that the use of a cane, which was necessary due to his lumbar spine condition, caused his CTS. However, for the reasons discussed above regarding Claimant's use of the cane, I find that it is unlikely that use of a cane has caused Claimant's CTS. In particular, Claimant's use of the cane was neither frequent nor substantially weight-bearing, and thus it does not involve the type of repetitive motion or pressure on the nerve that generally causes CTS. Dr. Capen stated that "carpal tunnel is the main peripheral nerve compression problem that is directly linked with weight-bearing with the upper extremities." TR at 208. However, Claimant does not hold his cane in the position, with the necessary frequency, or with sufficient pressure to cause CTS. Moreover, Dr. Lorman testified that CTS is more caused by repetitive motion than weight-bearing. TR at 214.

In addition, Dr. Capen could not explain why Claimant also has carpal tunnel in his right hand when he only uses the cane in his left hand. TR at 261. A more plausible explanation for Claimant's carpal tunnel is that is arose idiopathically or from his earlier work or his activities of daily living, and that it is worse on his left hand merely because that is his dominant hand which has received more use over his lifetime.

As discussed above, Claimant's use of his cane is too infrequent and non-weight-bearing to cause or aggravate his CTS, as there is no evidence that such use of a cane causes CTS.

For all of these reasons, I find that Claimant has failed to demonstrate a change in condition with regard to his CTS related to or caused by his 1983 injury.

5. Depression and Anxiety

Claimant's Trial Brief raises his psychological condition as a ground for modification, but this was not raised at all at the hearing and was only mentioned in passing in his Closing Brief. TR at 202, 261; ALJX 1 at 4.

Claimant had mental problems in 1988. On June 30, 1987, Dr. Strazynski requested a psychological consultation because Claimant was suffering from "severe depression due to what he conceives failure as a father, husband and provider for his family." EX 2 at 133. At the 1988 hearing, Judge Schneider found that Claimant was very upset and ordered that psychiatric or psychological treatment be provided. CX 4 at 6. However, Claimant has never sought or received any psychological treatment. CX 10 at 4, 15.

Claimant has also had mental problems since the 1988 decision. On February 11, 2004, Dr. Jarminski diagnosed for the first time depression and anxiety. CX 8 at 98; Ex 7 at 385. Claimant then saw Dr. Procci on March 15, 2004, who diagnosed major depressive disorder. CX 10. Then, Claimant was evaluated on May 22, 2004 by Dr. Marvin Klemes, M.D. who diagnosed no psychiatric or personality disorder. EX 9. During his evaluations with Dr. Klemes, Claimant repeatedly and adamantly denied having any psychiatric problems. EX 9 at 469-470. On April 7, 2005, Dr. Farran noted continued depression complaints and that Claimant had not received

any therapy or anti-depressant medication. TR at 291. On April 27, 2005, Dr. Capen diagnosed depression and anxiety, and referred Claimant to a psychiatrist. TR at 219.

I find Dr. Procci's diagnosis of depressive disorder persuasive, especially given the depression symptoms and complaints that have been noted by other doctors over the years. However, there is insufficient information regarding Claimant's mental condition in 1988 to determine whether his current diagnosis constitutes a change in condition. Thus, I find that Claimant has not satisfied his burden of demonstrating a change in his psychiatric condition related to or caused by his 1983 injury.

Temporary vs. Permanent Disability

Claimant asserts he is temporarily disabled in that he could improve with certain surgeries or treatment.

I find that Claimant's lumbar and cervical spine conditions are permanent and stationary because there are no treatments he will accept that will lead to improvement, only palliative treatments. TR at 209-11. Even Dr. Capen conceded at the hearing that Claimant's physical condition is permanent, but his pain levels will wax and wane. TR at 264.

Similarly, Claimant's mental condition is permanent and stationary because he appears unwilling to admit that he has a mental disability or accept psychiatric treatment.

Thus, Claimant's assertion the he is temporarily disabled can only be based upon his left shoulder and CTS conditions, as these are the only conditions for which there are treatments available that he is willing to undergo and that promise to improve his condition. However, because I have found that Claimant's left shoulder and CTS conditions are unrelated to his 1983 work injury, his condition as it relates to the 1983 work injury remains permanent and stationary.

Need for Medical Treatment/Procedures

Section 7(a) of the Act provides that the "Employer shall furnish medical, surgical, and other attendance or treatment…for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a). In order for medical expenses to be assessed against an employer, the expense must be both reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Reasonable and necessary medical expenses are those related to and appropriate for the diagnosis and treatment of the industrial injury. 20 C.F.R. § 702.402; *Pardee v. Army & Air Force Exchange Serv.*, 13 BRBS 1130, 1138 (1981). A claimant establishes a prima facie case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-58 (1984). Claimant carries the burden to establish the necessity of such treatment rendered for his work-related injury. *See generally Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112 (1996); *Wheeler v. Interocean Stevedoring Inc.*, 21 BRBS 33 (1988).

Claimant seeks authorization for left carpal tunnel release procedure and for discogram

studies of his cervical spine. (Claimant's Trial Brief at 2). Dr. Capen has also recommended shoulder surgery to Claimant, but has not sought authorization for that procedure. TR at 223-24.

Carpal Tunnel Release

The medical experts in this case dispute whether a carpal tunnel release procedure is necessary, or would be beneficial, for Claimant. Claimant's treating physician, Dr. Capen, believes such a procedure is necessary and has sought authorization for it. However, Dr. Capen concedes that Claimant has had the carpal tunnel for so long that he may already have permanent nerve damage. TR at 223. Dr. Capen also noted that "unless something is done to stop the need for the use of the cane, you might be dealing with temporary or a more partial relief if he continues to go back to the use of the cane" after a carpal tunnel release. TR at 223. Similarly, Dr. Lorman concedes that surgery would improve Claimant's condition. TR at 184-85. On the other hand, Dr. Farran believes "it would be a major mistake to operate on [Claimant's] hand" because it is improving, there is no denervation or muscle abnormalities, and his numbers are not significant to warrant the risks of surgery. TR at 302-03.

However, because I find that Claimant's CTS is not caused by or related to the 1983 injury, Employer is not required to pay for the carpal tunnel release procedure.

Discogram

Claimant's treating physician, Dr. Capen, has sought authorization for a discogram of the cervical spine, and Claimant seeks a ruling that he is entitled to such procedure.

However, I find that such a procedure is neither reasonable nor necessary at this time. First, Claimant testified that he will never have neck and back surgery, because he has suffered enough and is afraid of being permanently crippled. TR at 45-46, 64.

Second, Dr. Capen states that he would not do a discogram until a patient was ready to think about having back surgery. TR at 251. He said that Claimant had been thinking about undergoing a discogram and possibly surgery, but has since changed his mind. TR at 251. Claimant indicated that he would not be willing to undergo discogram studies of his cervical spine, since he had such a negative experience with his myelogram, which is a similar procedure. TR at 96.

Lastly, Dr. Lorman opines that a discogram of the cervical spine is not appropriate for Claimant because the EMG and nerve conduction tests show no radiculopathy and the clinical exam shows no nerve root pressure. TR at 147-48. Thus, since Claimant refuses spinal surgery, a discogram would be futile. TR at 148.

Should Claimant decide at some point that he wants cervical spine surgery, neither the discogram nor the surgery would be chargeable to Employer because Claimant's cervical spine problems are not related to the 1983 work injury

b. Change in Economic Condition

Section 22 of the Longshore Act ``allows modification whenever a changed combination of training and economic (let alone physical) circumstances reduces, restores, or improves wage-earning capacity." *Rambo II*, 31 BRBS at 58. Thus, a change in a claimant's economic condition may be properly considered for section 22 modification, even without a change in physical condition. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291 (1995). A change in economic condition need not be substantial to warrant section 22 modification. *See Ramirez v. Southern Stevedores*, 25 BRBS 260 (1992).

A claimant may request modification based on a change in economic condition on the grounds that employment opportunities previously considered suitable are not suitable. The standards for establishing suitable alternative employment (or lack thereof) apply in a modification proceeding. *Blake v. Ceres Inc.*, 19 BRBS 219.

In the 1988 Decision and Order, Judge Schneider found that Claimant's average weekly wage was $587.52 and his retained earning capacity was $350.00 per week, which resulted in a net disability rate of $237.62 per week. Accordingly, Claimant was awarded permanent partial disability compensation in the amount of $158.41 per week.

Employer argues that "Claimant offered no evidence or argument in support of an economic theory of modification that Claimant has suffered a decrease in wage earning capacity." ALJX 2 at 2. Claimant argues that he is temporarily totally disabled at this time, and unable to perform any work. ALJX 1 at 8. In the alternative, should I find that Claimant is permanently partially disabled, Claimant argues that his retained earning capacity should be reduced from $350.00 to $173.52, based on the wages of the jobs identified by Employer in its 2003 and 2005 Labor Market Surveys. ALJX 1 at 8.

Partial vs. Total Disability

"[O]nce the party seeking modification demonstrates a change in condition, Claimant must establish only his continuing inability to perform his pre-injury job; the burden then shifts to employer to establish the availability of suitable alternate employment." *Vasquez v. Continental Marine of San Francisco*, 23 BRBS 428 (1990).

If a claimant has established that with his or her physical restrictions he or she cannot return to his or her regular work, he or she will be considered permanently totally disabled unless the employer establishes suitable alternative employment. *Clophus v. Amoco Oroduction Co.*, 21 BRBS 261 (1988). The employer must show the existence of realistically available job opportunities within the geographical area where the claimant resides which he or she is capable of performing, considering his or her age, education, work experience, and physical restrictions. *See Bumble Bee Seafoods v. Director, OWCP*, 629 F.2d 1327 (9th Cir. 1980); *Pilkington v. Sun Shipbuilding & Dry Dock Co.*, 9 BRBS 473 (1978). If the employer meets its burden and establishes suitable alternative employment, the burden shifts back to the claimant to prove a diligent search and willingness to work. *See Edwards v. Director, OWCP*, 999 F.2d 1374(9th Cir. 1993); *Williams v. Halter Marine Service*, 19 BRBS 248 (1987).

The judge may rely on the testimony of vocational counselors regarding specific job openings to establish the existence of suitable positions. *See Turney v. Bethlehem Steel Corp*., 17 BRBS 232 (1985). The counselors must identify specific available positions; labor market surveys are not enough. *See Campbell v. Lykes Bros. Steamship Co.*, 15 BRBS 380 (1983). The judge may credit a vocational expert's opinion even if the expert did not examine the claimant, as long as the expert was aware of the claimant's age, education, industrial history, and physical limitations when exploring the local job opportunities. *See Southern v. Farmers Export Co.*, 17 BRBS 64 (1985).

Judge Schneider found that Claimant was unable to return to his pre-injury longshore position. Because Claimant's condition has not improved, he remains unable to return to his usual work.

Since Claimant has established that he is unable to return to his former position, Employer has the burden of showing that there are alternative positions available to him. Employer provided three labor market surveys by its vocational expert, Nedra Meyers. Claimant's vocational expert, Kathryn Melamed, responded to Ms. Meyers' first labor market survey with reasons why every job identified was unsuitable for Claimant. Claimant himself also responded to Ms. Meyer's labor market survey with criticisms of her analysis. Ms. Meyers apparently took these responses into consideration in her most recent labor market survey, which is dated June 13, 2005, in that she only identified positions that involved solely sedentary work and no computer use. The positions included four parking cashier positions and four telephone positions: surveyor, interviewer, switchboard operator, and appointment setter. EX 6 at 349.10-349.15.

I find Claimant credible when he testified that he has pain flare-ups two to three times per month, during which he is severely limited in his mobility for two to three days. Given such a need for frequent absences from work, Claimant would be effectively unemployable in any of the positions identified by Employer. However, because I find that Claimant's increased pain is caused by progression of his pre-existing degenerative disc disease and aging, rather than his work-related injury, it may not be taken into account in determining his degree of disability.

Although it is "well established with respect the claimant's condition before injury" that an employer takes the employee as it finds him, "[t]he employer cannot reasonably be held responsible for changes in condition, or new conditions, arising after the injury, unless the injury caused or accelerated those changes." *Zahn v. Hugo Neuproler Co.*, 21 BRBS 585, 607 (ALJ)(Nov. 2, 1988). Thus, only those conditions and work restrictions that preceded or were caused or aggravated by the work injury may be taken into account when determining a claimant's degree of disability. In other words, "[w]hether the claimant's compensable permanent disability is total or partial, therefore, depends on whether he would be employable in available positions with the…limitations arising from the injury, and with the [condition] existing at the time of the injury, but without regard to further progress in the [pre-existing condition]." *Id.* Conditions or work restrictions that are unrelated to and arise after the work injury may not be taken into account. *See, e.g., Livingston v. Jacksonville Shipyards, Inc.*, 32 BRBS 123 (June 24, 1998)(citing cases that held that a claimant's pre-injury criminal record may be considered in determining suitable alternative employment, but that post-injury incarceration

or criminal penalties (especially where temporary) should not be considered).

Because the increased pain and other conditions that Claimant has developed since the 1988 decision are unrelated to the 1983 work injury, they may not be considered in determining his degree of disability. Claimant's compensable disability remains unchanged.

Retained Earning Capacity

As an alternative to arguing that he is totally disabled, Claimant argues that his retained earning capacity is less than the amount found by Judge Schneider in 1988, which was $350.00 per week. Claimant asserts that his retained earning capacity is $173.52, based on the average of the wages paid by the positions identified in Employer's labor market surveys. (CB at 8).

However, as discussed above, I find that Claimant's condition as it relates to the 1983 injury has not changed since Judge Schneider's 1988 decision, when he was found to be partially disabled with a retained earning capacity of $350.00 per week. Any new conditions or worsening of his condition, are due to progression of his degenerative disc disease, aging, and other non-work-related causes. Thus, although Claimant may be less able to work now than in 1988, any difference in his ability to work is not related to the 1983 work injury and is not compensable. As discussed above, only those conditions and work restrictions that preceded or were caused or aggravated by the work injury may be taken into account when determining Claimant's retained earning capacity. Thus, to prove a change in economic condition and reduce his retained earning capacity, Claimant would have to demonstrate that the amount he could earn today (adjusted for inflation), with only the conditions and work restrictions that are related to his 1983 work injury, is less than $350.00. Claimant has not met this burden.

ORDER

Based on the foregoing findings of fact and conclusions of law, **IT IS HEREBY ORDERED** that Claimant's petition for modification is **DENIED**.

A

GERALD M. ETCHINGHAM
Administrative Law Judge

San Francisco, California